

# Indigent Medication Update/Extension Form

**Referral for Continued Temporary Assistance through the S.D. Indigent Medication Program**

*The Department of Social Services, Division of Behavioral Health will use this information to determine eligibility for continued **temporary** coverage of psychotropic medication, medication assistance for the treatment of substance use disorders and /or maintenance treatment, and/or related laboratory work.*

***Entire application must be completed. Please print clearly.***

**Current Date:** \_\_\_\_\_ **Date of Original Application (if known):** \_\_\_\_\_  
 \_\_\_\_\_ **Update** \_\_\_\_\_ **1<sup>st</sup> Extension** \_\_\_\_\_ **2<sup>nd</sup> or more (must be staffed with Division prior to reauthorization)**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Person assisting with this form & email address:** \_\_\_\_\_

**Agency Name:** \_\_\_\_\_

**Income & Insurance**

Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_ Volunteer work \_\_\_\_\_ Hrs/week \_\_\_\_\_

If “No” are you actively seeking employment? Yes \_\_\_\_\_ No \_\_\_\_\_ If “No”, why not? \_\_\_\_\_

Yearly Household Income, including SSI/SSDI: \_\_\_\_\_

SSI/SSDI Application Status: Applied/Pending \_\_\_\_\_ Denied \_\_\_\_\_ Appealed \_\_\_\_\_ Have not applied yet \_\_\_\_\_

Approved \_\_\_\_\_ Effective Date \_\_\_\_\_

Do you currently have any insurance plan or Medicaid that pays for prescription drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have Medicare Benefits? **Part A** Yes \_\_\_ No\_\_ **Part B** Yes\_\_ No\_\_ **Part D** Yes \_\_\_ No\_\_

Have you applied for Medicare Part D insurance for your prescriptions? Yes \_\_\_\_\_ No \_\_\_\_\_

**Are you currently pursuing alternate funding options? (Required for continued assistance)**

**Prescription Assistance** \_\_\_\_\_ **Insurance/Medicaid** \_\_\_\_\_ **Self-Pay/Budgeting** \_\_\_\_\_ **Samples** \_\_\_\_\_

Medication/ Lab Requested	Milligrams	Quantity	Update/ Extension	Reason for Extension

***Pharmacy/Healthcare Center where lab work is to be done:***

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**Return forms to:**

**Division of Behavioral Health**  
**700 Governors Drive**  
**Pierre, SD 57501**

**Phone: (605) 773-3123**  
**Fax: (605) 773-7076**  
**Email: DSSBHINDMED@state.sd.us**

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605-773-3305.

**Español (Spanish)** - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

**Deutsch (German)** - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).