Referral for Temporary Assistance through the South Dakota Indigent Medication Program

*The Department of Social Services, Community Behavioral Health will use this information to determine eligibility for **temporary** coverage of psychotropic/alcohol cessation medications and/or related laboratory work.* ***Entire application must be completed.*** ***Please print clearly.***

Date: _____

Person assisting with this form & email address: _____

Client Name: _____
First *MI* *Last*

Address:_____ Date of Birth: _____

City/State/Zip: _____ Soc. Sec. #:_____

Telephone Number: _____ Sex: Male _____ Female_____

Married _____ Single _____Widowed_____ Separated _____# People in household_____

Diagnosis: _____

Last hospitalization for mental illness and/or alcohol dependence:

Date: _____Where:_____

Income & Insurance:

Are you currently employed? Yes_____ Hrs/week _____ No_____ Volunteer work _____

If no, are you actively seeking employment? Yes___ No___ If no, why not?_____

Are you currently incarcerated? Yes___ No___ If yes, where and release date?_____

Yearly Household Income: Self $_____ Spouse $_____

SSI/SSDI Application Status: Applied/Pending____ Denied____ Appealed____ Approved ___Have not applied yet: ____

Supplemental Security Income (check on the first of the month): $_____

Soc. Sec. Disability Insurance (check on the 3rd of the month): $_____

Have you applied for Medicaid or health insurance through the Federal Exchange (healthcare.gov)? Yes___ No__

Have you applied for any Patient Assistance Programs? Yes____ No ___

If yes, which ones? _____

Do you currently have any insurance plan that pays for prescription drugs including Medicaid: 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 ____ If no, why not? _____

If yes, what plan are you on? _____

Pharmacy:

Pharmacy: _____

Address: _____City/State/Zip: _____

Phone: _____ Fax (if known):_____

Health care center where lab work is to be done:

Health care center: _____

Address: _____City/State/Zip: _____

Phone: _____ Fax (if known):_____

Community Mental Health Center/Substance Abuse Provider:_____

On Waiting List: Yes_____ No_____ ***Appointment Date:***_____

Psychotropic/ Alcohol Cessation Medication (If non-psychotropic/ alcohol cessation medication, reason must be indicated)	**Milligrams/ Strength**	**Frequency/ Quantity**	**Can generic be used? Y/N**	**Why is this medication prescribed?**	**Co-pay amount**	**Medicare Part D Donut Hole Y/N**

Lab test needed	**Frequency**	**Why is this lab test ordered? (Please list current psychotropic medications that relate to labs being requested.)**

I declare and affirm under the penalties of perjury that this information has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

I agree to inform the South Dakota Department of Social Services, Community Behavioral Health if Medicaid, private health insurance, or patient assistance programs are obtained anytime within the approved application year.

Consumer/Guardian Signature:_____Date:_____

Return forms (release of information, referral, drug list, and denial notice) to:

Community Behavioral Health
Kneip Building
700 Governors Drive
Pierre, South Dakota 57501

Phone: (605) 773-3123
Fax: (605) 773-7076
Toll Free-1- 855-878-6057
Email: DSSBHINDMED@state.sd.us

DEPARTMENT OF SOCIAL SERVICES, COMMUNITY BEHAVIORAL HEALTH
AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize the Department of Social Services, Community Behavioral Health to release and/or exchange information both orally and in writing, with respect to diagnosis and course of treatment of my mental illness and/or alcohol dependence with any Community Mental Health Center/Substance Abuse Provider, pharmacy, medical provider, provider of laboratory services, and/or pharmaceutical programs.

Consumer/Guardian Signature _____ DATE _____

I acknowledge that the Department of Social Services, Community Behavioral Health will pay for my psychotropic/alcohol cessation medications and/or related lab costs on a time-limited basis, as determined by the Department of Social Services, Community Behavioral Health.

I understand the above criteria and the terms/conditions of my participation in the program offered through the Department of Social Services, Community Behavioral Health.

I agree to the following as terms/conditions of this medication/laboratory funding agreement:

- **I will take all psychotropic/alcohol cessation medications as prescribed.**
- **I will be responsible to cover the cost of replacing lost or damaged medications.**
- **I will not sell, give away or otherwise distribute medications intended for personal use.**
- **I will keep all scheduled psychiatric/substance abuse provider appointments and comply with treatment.**
- **I will develop a plan for long term needs as state funding is limited.**
- **I understand that funding may end with no greater than a 30 day notice.**
- **I will continue to exhaust all other funding resources.**
- **I authorize the exchange/release of relevant and necessary medical/psychiatric/substance abuse information to the Department of Social Services, Community Behavioral Health.**
- **I agree to inform the Department of Social Services, Community Behavioral Health if Medicaid, private health insurance, patient assistance programs, and/or my financial status would otherwise change.**
- **I understand that failure to comply with the above-based requirements will result in my termination from the program and/or repayment.**
- **I understand that if this application is not complete or correct, this application will be destroyed.**
- **I understand that this application will be effective one year from the date originally signed.**
- **I understand that I may revoke my consent at any time and that revocation is effective upon receipt, except to the extent previously relied upon.**

Consumer/Guardian Signature _____ DATE _____

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NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Effective Date: April 14, 2003

The Notice of Privacy Practices tells you how we may use or disclose protected health information (PHI) about you. Not all situations will be described. We are required to give you a notice of our privacy practices about your protected health information.

I, _____(Client/Patient name), have been given a copy of the Department of Social Services' Notice of Privacy Practices and understand that I may ask questions about how my PHI will be used.

_____ _____
Signature - Client/Patient Date

_____ _____
Signature - Legal Representative of Client/Patient (if applicable) Date

_____
Relationship to Client/Patient

Please return form to address listed below:

Department of Social Services
Division of Behavioral Health
700 Governors Drive
Pierre, SD 57501-5070

This document is available in alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).
Contact us at: Phone: 1.855.878.6057 Fax: 605.773.7076 or 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).

South Dakota Department of Social Services

NOTICE OF PRIVACY PRACTICES

(Effective: April 1, 2015)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your health and claims record.**
  - You can ask to see or get an electronic or paper copy of your health and claims record and other health information we have about you. Ask us how to do this.
  - We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records.**
  - You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
  - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communications.**
  - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests will be granted.
- **Ask us to limit what we use or share.**
  - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.**
  - You can ask for a list of the times we've shared your health information for the six years prior to the date you ask, who we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.**
  - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will promptly provide you with a paper copy.
- **Choose someone to act for you.**
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights have been violated.**
  - You can file a complaint if you feel we have violated your rights by contacting us using the information on the last page of this brochure.
  - We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in our patient directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written authorization:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

We may contact you for:

- Appointment reminders
- To tell you about or recommend treatment options, alternatives, health-related benefits or services that may be of interest to you.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

- **For Treatment.** We can use your health information and share it with other professionals who are treating you.
  - For example, information may be shared to create and carry out a plan for your treatment.
- **For Payment.** We may use or disclose your health information to obtain payment or to pay for the health care services you receive.
  - For example, we may provide protected health information to your health plan in order to bill for health care services provided to you.
- **For Health Care Operations.** We may use or disclose your health information in order to manage our programs and activities and to contact you when necessary.
  - For example, we may use protected health information to review the quality of services you receive or we may share your information with medical or nursing students for educational purposes.

OTHER USES AND DISCLOSURES

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues**
  We can share health information about you for certain situations such as:
  - Preventing disease.
  - Helping with product recalls.
  - Reporting adverse reactions to medications.
  - Reporting suspected abuse, neglect, or domestic violence.
  - Preventing or reducing a serious threat to anyone's health or safety.
- **Research purposes**
  - We may use your health information for studies and to develop reports. Any studies or reports prepared for research purposes would not identify specific people.
- **To comply with the law.**
  - We will share information about you if state or federal laws require it, including with the U.S. Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
  - We can share health information with a coroner, medical examiner or funeral director when an individual dies.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director.**
  - We can share health information about you with organ procurement organizations.
  - We can share health information with a coroner, medical examiner or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests.**
  - For workers' compensation claims.
  - For law enforcement purposes or with a law enforcement official.
  - With health oversight agencies for activities authorized by law.
  - For special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions**
  - We can share health information about you in response to a court or administrative order, or in certain circumstances to a subpoena.
- **Health Oversight Activities**
  - We may use or disclose information to inspect or investigate health care providers.
- **We will not share any alcohol or substance abuse treatment records without your written authorization.**

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time, but understand that we cannot take back any uses or disclosures already made with your authorization. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

How to Contact us to Review, Correct, or Limit Your Protected Health Information

You may contact your local Department of Social Services' office or contact:

Department of Social Services
Privacy Officer
700 Governors Drive
Pierre, South Dakota 57501
Phone: (605) 773-3165
Email: dssinfo@state.sd.us

How to File a Complaint or Report a Problem

You may contact those listed above if you would like to file a complaint or report a problem with how we have used or disclosed information about you. **Your benefits will not be affected by any complaints you make.** The Department cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights by contacting:

Region VIII, Office of Civil Rights
Department of Health and Human Services
1961 Stout St., Room 1185 FOB
Denver, CO 80294-3538
Phone: (303) 844-2024
TDD: (303) 844-3439
Fax: (303) 844-2025

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Language Assistance

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

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

3. **繁體中文 (Chinese) -** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電1-800-305-9673（TTY：711）

4. **ကညီ (Karen) -** ဟ်သူဉ်ဟ်သး-နမ့်ကတိၤ ကညီကျိာ်အဃိ, နမၤနှ်ကျိာ်အတ၊်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိ;1-800-305-9673 (TTY: 711).

5. **Tiếng Việt (Vietnamese) -** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-305-9673 (TTY: 711).

6. **नेपाली (Nepali) -** यान दनुहोसः् तपाइ ले नेपाल बो नह छ भन तपाइ को िन त भाषा सहायता सवाह नःश क पमा उपल ध छ । फोन गनुहोसर् ्1-800-305-9673 (ट टवाइ: 711)

7. **Srpsko-hrvatski (Serbo-Croatian) -** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-305-9673 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

8. **አማርኛ (Amharic) - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፣ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-305-9673 (መስማት ለተሳናቸው: 711).**

9. Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-305-9673 (TTY: 711).

10. **Tagalog (Tagalog – Filipino) -** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-305-9673 (TTY: 711).

11. **한국어 (Korean) -** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-305-9673 (TTY: 711)번으로 전화해 주십시오.

12. **Русский (Russian) -** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-305-9673 (телетайп: 711).

13. **Cushite Oroomiffa (Oromo) -** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-305-9673 (TTY: 711).

14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 1-800-305-9643 (TTY: 711).

15. **Français (French) -** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-305-9673 (ATS : 711)

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Notice of Nondiscrimination

As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Social Services directly or through a contractor or any other entity with which the Department of Social Services arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Social Services directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence against Women.

The Department of Social Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact your local DSS office.

If you believe that DSS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a discrimination complaint or grievance with: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. Phone: (605) 773-3305, Fax: (605) 773-7223, DSSInfo@state.sd.us . You can file a discrimination complaint or grievance in person or by mail, fax, or email. If you need help filing a discrimination complaint or grievance, the Discrimination Coordinator, Director of DSS Division of Legal Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, and 28 CFR Part 35, the Omnibus Crime Control and Safe Streets Act of 1968, Title IX of the Education Amendments of 1972, Equal Treatment for Faith-based Religions at 28 CFR Part 38, the Violence Against Women Reauthorization Act of 2013, and Section 1557 of the Affordable Care Act.