Referral for Temporary Assistance through the South Dakota Indigent Medication Program

*The Department of Social Services, Division of Behavioral Health will use this information to determine eligibility for **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.***

Date: _____

Person assisting with this form & email address: _____

Client Name: _____
First *MI* *Last*

STARS ID, if applicable: _____Date of Birth: _____ Social Security Number xxx-xx- _____

Address: _____
Address *City* *State* *Zip Code*

Telephone Number: _____ Sex: Male _____ Female_____

Married _____ Single _____ Widowed_____ Separated _____ # People in household_____

Diagnosis: _____

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: ____

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

If yes, which ones? _____

If no, why not? _____

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 yes, what plan are you on? _____

If no, why not? _____

Mental Health Provider/Agency /Substance Use Disorder Provider/Agency: _____
Appointment Date:_____ Services Receiving: _____

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):_____

Medication	Milligrams/ Strength	Frequency/ Quantity	Can generic be used? Y/N	Why is this medication prescribed (Diagnosis)?	Co-pay amount	Medicare Part D Donut Hole Y/N

Lab test needed	Frequency	Why is this lab test ordered? (Please list current 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 take all medications as prescribed by my healthcare provider.

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

Consumer/Guardian Signature: _____Date: _____

Return form (Referral, Release of Information, medication/lab list and Notice of Privacy Practices) to:

Division of Behavioral Health
700 Governors Drive
Pierre, SD 57501

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

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

I hereby authorize the Department of Social Services, Division of 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 substance use disorder with any Mental Health Provider/Substance Use Disorder Provider, pharmacy, medical provider, provider of laboratory services, and/or pharmaceutical programs.

Consumer/Guardian Signature _____ DATE _____

I acknowledge that the Department of Social Services, Division of Behavioral Health will pay for my psychotropic medication, medication assistance for the treatment of substance use disorders, to include cessation and/or maintenance treatment, and /or related laboratory work on a time-limited basis, as determined by the Department of Social Services, Division of Behavioral Health.

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

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

- **I will take all psychotropic medication and medication for the assistance of treatment of substance use disorders, to include cessation and/or maintenance treatment 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, Division of Behavioral Health.**
- **I agree to inform the Department of Social Services, Division of 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

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).

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. **unD (Karen) -** ymol.ymo;=erh>uwdR unDusdmtCd< erRM> usdmtw>rRpXRvX wvXmbl.vXmphR eDwrHRb.ohM.vDRI ud;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 दनुहोस:् तपाइ ले नेपाल बो नह छ भन तपाइ को िन त भाषा सहायता सवाह नःश क पमा उपल ध छ । फोन गनुहोस् ्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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