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 _____

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)

DSS
Strong Families - South Dakota's Foundation and Our Future

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.