Office Use Only: DSS-EA-249 03/2019 **Recipient ID:** ____________________ **Date:** __________________________

State of South Dakota – Department of Social Services
Disabled Children Program

Section A

Child's Information

Please print and use dark ink. If you need more room, use a separate sheet.

Try and fill out as much of the form as you can.

If you have questions, contact the Long-Term Care office at: 605-394-2525 or 800-644-2914

Are you completing this form for an initial application or annual review? ☐ Application ☐ Annual Review	
Child's First Name:	
Child's Middle Name:	
Child's Last Name:	
Child's Birth Date:	______/______/______
Child's Social Security Number:	
Child's Sex:	☐ Male ☐ Female
Hispanic or Latino? *Optional*	☐ Yes ☐ No
Child's Race: *Optional*	☐ Native American or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ White
Parent/Guardian Name(s):	
Current Address:	
City, State, ZIP:	
Cell Phone Number(s):	
Home Phone Number(s):	
Mailing Address:	
City, State, ZIP:	
Email:	
Preferred Contact Method:	☐ Mail ☐ Cell ☐ Home Phone ☐ Email

Provide information for the current parent, guardian, or custodian.

If the mailing address is the same as the current address, you may leave it blank.

Section B

Citizenship

Provide citizenship documentation if not a U.S. citizen.

Is your child a U.S. Citizen?	☐ Yes (go to Section C) ☐ No
Is your child a refugee or a legally admitted immigrant?	☐ Yes ☐ No
What date did your child enter the U.S.?	______/______/______
Is your child registered with the U.S. Citizenship and Immigration Services?	☐ Yes (proceed to next lines) ☐ No
Child's Document Type:	
Child's Alien, I-94, or Passport Number:	

Section C

Income

List all income and benefits that your child receives.

Examples of income include*: Child Support, Social Security, SSI, dependent VA benefits, dividends, insurance payments or annuities, interest income on bonds, CDs, or savings accounts, tribal lease income, fundraisers, contributions, received donations, or any other income.*

Have you applied for Supplemental Security Income (SSI) for your child?	☐ Yes (attach verification) ☐ No
Does your child receive income?	☐ Yes ☐ No (go to Section D)

INCOME INFORMATION

Attach verification of income type, gross/net amount, and frequency.

Income Type	Gross Amount	Frequency

Section D

Resources

Reminder: Answer the questions only for resources that are owned. Include jointly owned accounts.

Please attach the most recent 3 months of bank statements.

If you need more room, you can copy the pages.

Resources/Assets

Attach verifications on all claimed resources/assets. Verifications must clearly show the resource/asset type, current value, and ownership information.

Does your child own any checking account(s)? ☐ Yes ☐ No

CHECKING ACCOUNT		
	Bank Name:	Bank City, State:
	Account Number:	Account Balance:
	Names on Account:	

Does your child own any savings account(s)? ☐ Yes ☐ No

SAVINGS ACCOUNT 1	Bank Name:	Bank City, State:
	Account Number:	Account Balance:
	Names on Account:	
SAVINGS ACCOUNT 2	Bank Name:	Bank City, State:
	Account Number:	Account Balance:
	Names on Account:	

Does your child own any cash? ☐ Yes – Amount: ☐ No

***Examples of other accounts include**: Direct Express Federal Benefits cards, CDs, savings bonds, money markets, health savings accounts, stocks, mutual funds, annuities, or any other account.*

Does your child own any other accounts? ☐ Yes ☐ No

OTHER ACCOUNTS		
	Bank/Company Name:	Bank City, State:
	Account Number:	Value:
	Names on Account:	
	Account Type:	

***Examples of other assets include:** prepaid burial funds, trusts, land, buildings, vehicles, farm equipment, livestock, or any other item of value.*

Does your child have any ownership interest in any other assets? ☐ Yes ☐ No

Asset Type:	Asset Value:
Asset Type:	Asset Value:
Asset Type:	Asset Value:
Asset Type:	Asset Value:

Section E

Insurances

Life Insurance: *Attach verification of the current face and cash value of any life insurance policies owned by your child.*

If it is assigned to a prepaid burial fund, please provide a copy.

Health Insurance: *Attach a copy of the front and back of any insurance cards.*

Is your child the owner of any life insurance policies? ☐ Yes ☐ No

LIFE INSURANCE		
	Policy Owner:	Insured Person:
	Policy Number:	Company:
	Company Address:	
	Face/Cash Value:	Policy Type:
	Assigned to burial? ☐ Yes (if yes, provide a copy) ☐ No	

Is your child covered by health insurance? ☐ Yes ☐ No

HEALTH INSURANCE – 1		
	Policy Holder's Full Name:	
	Policy Number:	Group Number:
	Company Name:	
	Company Address:	
	Coverage Start Date:	Coverage End Date:
	Employer Name:	
	Coverage Type (mark all):	☐ Inpatient ☐ Outpatient ☐ Dental ☐ Cancer ☐ Medicare Supplement ☐ Other (Ex: Prescription)

HEALTH INSURANCE – 2		
	Policy Holder's Full Name:	
	Policy Number:	Group Number:
	Company Name:	
	Company Address:	
	Coverage Start Date:	Coverage End Date:
	Employer Name:	
	Coverage Type (mark all):	☐ Inpatient ☐ Outpatient ☐ Dental ☐ Cancer ☐ Medicare Supplement ☐ Other (Ex: Prescription)

Section F

Medical, Educational, & Developmental Information

Educational, medical, and developmental records will be requested on your child's behalf for disability and level of care determinations.

Does your child attend school? ☐ Yes ☐ No

Does your child have an Individualized Education Plan (IEP)? ☐ Yes ☐ No

If yes, please provide a complete copy of the most current IEP.

EDUCATIONAL INFORMATION		
	School Name:	
	School Address:	
	Grade Level:	Date of last IEP (if applicable):

Physician Information	
Does your child have a primary care physician? ☐ Yes ☐ No	
Name:	Specialty:
Clinic Name:	
Clinic Address:	
How often is your child seen by this physician?	

List any other physicians who care for your child.

PHYSICIAN 2	Name:	Specialty:
	Clinic Name:	
	Clinic Address:	
	How often is your child seen by this physician?	
PHYSICIAN 3	Name:	Specialty:
	Clinic Name:	
	Clinic Address:	
	How often is your child seen by this physician?	
PHYSICIAN 4	Name:	Specialty:
	Clinic Name:	
	Clinic Address:	
	How often is your child seen by this physician?	

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Section F

Medical, Educational, & Developmental Information *Continued*

Has your child been hospitalized in the last 12 months? ☐ Yes (if yes, complete below) ☐ No	
Hospital Name:	Dates:
Reason:	
Hospital Name:	Dates:
Reason:	

Has your child had a psychological evaluation? ☐ Yes ☐ No *If yes, provide a copy of the psychological evaluation.*	
Clinic Name:	Evaluation Date:
Clinic Address:	
Psychologist Name:	

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Does your child receive therapeutic services? ☐ Yes ☐ No	
PHYSICAL THERAPY	Physical therapy visits per week:
	Therapist Name:
	Therapy Agency:
	Agency Address:
OCCUPATIONAL THERAPY	Occupational therapy visits per week:
	Therapist Name:
	Therapy Agency:
	Agency Address:
SPEECH THERAPY	Speech therapy visits per week:
	Therapist Name:
	Therapy Agency:
	Agency Address:

Section F

Medical, Educational, & Developmental Information

Continued

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Physician Plan of Care

What skilled responsibilities are you trained in by your physician which are needed to care for your child (ex: injections, catheterization, caring for a catheter, port, or g-tube, etc.)? What signs, symptoms, or special situations have they trained you to monitor for in your child (ex: infection around a g-tube, oxygen levels, etc.)?

What is your child's primary medical diagnosis?

What is your child's prognosis?

If this is a new application, briefly describe your child's major condition(s) and when, with an approximate date, they first became evident. If this is a review, please describe any new medical conditions from the last year.

Section F

Medical, Educational, & Developmental Information
Continued

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Activities of Daily Living: Mobility & Hygiene *Mark your estimate of your child's ability for each activity.*		
Activity	**Ability**	**Explain assistance needed (numbers of persons, assistive devices, etc.)**
Walking	☐ Independent ☐ Needs Assistance ☐ Unable	
Crawling	☐ Independent ☐ Needs Assistance ☐ Unable	
Sitting Up	☐ Independent ☐ Needs Assistance ☐ Unable	
Transferring Positions (to bed or chair, etc.)	☐ Independent ☐ Needs Assistance ☐ Unable	
Bathing	☐ Independent ☐ Needs Assistance ☐ Unable	
Dressing	☐ Independent ☐ Needs Assistance ☐ Unable	
Grooming	☐ Independent ☐ Needs Assistance ☐ Unable	
Bladder Control	☐ Independent ☐ Needs Assistance ☐ Unable	
Bowel Control	☐ Independent ☐ Needs Assistance ☐ Unable	

Section F

Medical, Educational, & Developmental Information *Continued*

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Activities of Daily Living: Nutrition & Feeding

Which of the following describes your child's overall eating ability?

☐ Independent ☐ Needs Assistance ☐ Unable

Explain assistance, devices, and/or special precautions needed for eating, if any:

____

____

____

____

____

____

____

____

Please indicate below how your child is able to eat, how often, and for how long.

Method	Ability	Feedings per day	Feeding length	Explain special diet or formula
ORAL	☐ Independent ☐ Needs Assistance ☐ Unable			
GASTROSTOMY	☐ Independent ☐ Needs Assistance ☐ Unable			
NASOGASTRIC	☐ Independent ☐ Needs Assistance ☐ Unable			
PARENETERAL (INTRAVENOUS)	☐ Independent ☐ Needs Assistance ☐ Unable			

Section F

Medical, Educational, & Developmental Information *Continued*

Sight & Hearing

SIGHT

Is your child legally blind? ☐ Yes ☐ No | Is sight impaired? ☐ Yes ☐ No

Are any sight impairments correctable? ☐ Yes ☐ No

Explain impairment(s):

HEARING

Is your child legally deaf? ☐ Yes ☐ No | Is hearing impaired? ☐ Yes ☐ No

Are any hearing impairments correctable? ☐ Yes ☐ No

Explain impairment(s):

Respiratory

If your child requires any respiratory assistance, please complete this section.

Suction Type(s): ☐ Bulb ☐ Machine	**Frequency and other details:**
Oxygen	**Humidification:** **Hours per day:** **Liter flow:**
Chest Therapy	**Frequency and other details:**
Respirators and/or Ventilators ☐ Continuous	**Frequency and other details:**
Other	**Frequency and other details:**

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Section F

Medical, Educational, & Developmental Information
Continued

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Other Medical	
Skin	**Does your child have a history or evidence of skin breakdown, such as open wounds or bedsores?** ☐ Yes (list details, precaution, & treatment below) ☐ No
Seizures	**Does your child have a history or evidence of seizures?** ☐ Yes (list history, frequency, type, and level of control below) ☐ No
Physical Measurements	**What is your child's height?** **What is your child's weight?**
Other	**Briefly describe any other medical conditions:**

Section F

Medical, Educational, & Developmental Information
Continued

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Nursing Care

Does your child receive nursing care at home or school?

☐ Yes (if yes, complete the charts below based on the *type of nursing care* received)
☐ No (if no, go to the next page)

Does your child receive care from *a registered nurse*? ☐ Yes ☐ No	Registered Nurse's Name:						
	Agency:						
	Mark the hours and location of services for each day below.						
	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Hours →							
Location (home, school, etc.) →							

Does your child receive care from a *licensed practical nurse*? ☐ Yes ☐ No	Practical Nurse's Name:						
	Agency:						
	Mark the hours and location of services for each day below.						
	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Hours →							
Location (home, school, etc.) →							

Does your child receive care from a *home health aide*? ☐ Yes ☐ No	Home Health Aide's Name:						
	Agency:						
	Mark the hours and location of services for each day below.						
	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Hours →							
Location (home, school, etc.) →							

Section F

Medical, Educational, & Developmental Information
Continued

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Nursing - *continued*

Briefly describe the nursing treatment or procedures from the providers:

Behavior

Does your child have any behavioral problems (such as aggression, injury to self/others, uncooperative)? ☐ Yes (if yes, please provide details below) ☐ No

Section F

Medical, Educational, & Developmental Information

Continued

If you need more room, you can copy the pages or write the needed information on a separate sheet.

Medications

Complete the chart for all prescription & over the counter medications.

Medication Name	Dose	Frequency	Administration Method	Special Precautions
			☐ Oral ☐ G-Tube ☐ Injection ☐ Rectal ☐ Transdermal	
			☐ Oral ☐ G-Tube ☐ Injection ☐ Rectal ☐ Transdermal	
			☐ Oral ☐ G-Tube ☐ Injection ☐ Rectal ☐ Transdermal	
			☐ Oral ☐ G-Tube ☐ Injection ☐ Rectal ☐ Transdermal	
			☐ Oral ☐ G-Tube ☐ Injection ☐ Rectal ☐ Transdermal	

Equipment and Supplies

List all equipment, including orthotic and prosthetic devices (ankle, foot orthosis, braces, artificial limbs, etc.) and supplies used for your child (suction machine, oxygen, feeding pump & pole, etc.)

Item	Frequency of Use	Frequency of Replacement

Section G

Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, as amended, the South Dakota Department of Social Services, Division of Economic Assistance may not use or disclose your personally identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to the Department.

Section 1: Patient Information – I,			
Patient Name:			
Address:			
City, State, ZIP:			
Date of Birth:	______/______/______	**Phone Number:**	

hereby authorize the following individual(s) or entity(ies) to release the information described in Section 2 of this Authorization, to the persons, entities or classes of persons or entities listed in Section 3 of this Authorization: *(list all medical, psychological, educational, therapeutic, or other providers below)*

Facility Name:	
Facility Name:	
Facility Name:	
Facility Name:	
Facility Name:	
Facility Name:	
Facility Name:	

Section 2: Information Requested
Specific Information Requested: ALL RECORDS
Specific dates of service for the information requested: LAST 12 MONTHS
Purpose of the disclosure: MEDICAID ELIGIBILITY

Section 3: Recipient Information The specific information is to be released to the following person, entity(ies), or class(es) of person(s) or entity(ies):
DEPARTMENT OF SOCIAL SERVICES PO BOX 2440 RAPID CITY, SD 57709 PH: 605-394-2525 FAX: 605-394-2568

Section G

Authorization for the Use or Disclosure of Protected Health Information

Section 4: Disclosures

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. The South Dakota Department of Social Services, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in the Department's Notice of Privacy Policies, this consent form may be revoked at any time except to the extent the staff has taken action upon it. If not revoked, this Authorization to release protected health information will terminate in one year or upon the following specified date:______/_______/______. I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol treatment information, HIV testing information, and mental health treatment information may not be re-disclosed without my specific consent.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify. If the South Dakota Department of Social Services has been asked to allow or pay for a health care service on my behalf (such as a test or evaluation) for the purpose of providing the results of those services to someone else, I understand that if I choose not to authorize the disclosure of that information to the other person, the Department of Social Services may not allow the service or the payment for the services provided on my behalf.

Section 5: Signatures

____

Signature of parent, guardian, or authorized representative giving consent **Date**

____

Printed name of parent, guardian, or authorized representative giving consent **Relationship to participant/patient**

____

Phone number of the participant/patient, parent, guardian, or authorized representative

If signed by a personal representative, provide verification of the representative's authorization to act for the participant/patient.

REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately:

____

Signature **Date**

Section H

Statements of Understanding

Assignment of Medical Support, Insurance Proceeds

As application for and acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation of any rights to medical support, insurance proceeds, or both that the applicant or recipient may have. Any rights or amounts so assigned or subrogated shall be applied against the cost of the applicant's or recipient's care.

Disclosure of Annuities and State to be named as Remainder Beneficiary

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6012 requires individuals applying for long-term care medical assistance and an individual whose eligibility is being reviewed for purposes of determining whether the individual continues to be eligible for long-term care assistance to disclose the description of any interest the individual or the individual's spouse has in an annuity or similar financial instrument. Failure to disclose this information results in ineligibility for assistance. In addition, a recipient of long term care assistance must name the department as a preferred remained beneficiary of any interest the individual or individual's spouse has in an annuity or similar financial instrument purchased and owned after February 7, 2006.

Note: The annuity will also be considered a resource.

Privacy Act Statement

Federal and State Law and Regulations limit the use and disclosure of confidential information concerning applicants and recipients of economic and medical assistance programs to purposes directly related to the administration of those programs. When you apply for assistance, you will be asked to provide your Social Security Number (SSN) on the application form. Title 42 of the Code of

Federal Regulations Part 435.910(a) requires the furnishing of a SSN as a condition of eligibility for Medicaid. The Department uses your number in its computer processing of eligibility determination, welfare fraud investigation and audits. SSNs are also used to verify income information through agencies such as the IRS, Department of Labor, and Social Security Administration, etc., to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in benefits easier to implement and to determine the accuracy and reliability of information given to the department by applicant for and recipients of assistance.

Civil Rights Guarantee

The provisions of the Civil Rights Act of 1964, as amended, also apply to your case and department representatives shall not, on the grounds of race, color, creed, religion, sex, disability, ancestry, or national origin, exclude you from participation in, deny the benefits of, or otherwise subject you to discrimination under any program or activity administered by the department. Any person who feels that their civil rights have been violated may request a fair hearing. You may also file a complaint by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or by calling (605) 773-3305

Verifications

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials will verify information given on this form to determine if it is correct. A department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your Medical case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

Medicaid Estate Recovery Program

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased medical assistance recipients who were permanently institutionalized or who were at least 55 years of age and for whom the Department made a payment for nursing facility services, intermediate care facility services for individuals with intellectual disabilities, other medical institutional services, home and community based services, hospital services, and prescription drug services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be liable for recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended on behalf of the recipient. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by a recipient who has received a benefit from the Department of Social Services for the services of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach.

Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the nursing home or other facility if the resident was receiving medical assistance from the Department at the time of death. Information regarding the Estate Recovery Program can be located at **http://dss.sd.gov/keyresources/benefitfraud/estate.aspx.**

Section I

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>uwdRAunuD sdmtCd< AerRM> Ausdmtw>rRpXRvXA wvXmbl.vXmphRA eDwrHRb.ohM. vDRIAud; 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 ~दनहोसु :ः्‍ तपाइ~ले नेपाल~ बो नह छ भन तपाइ~को ~ि्‍न त भाषा सहायता सवाह ~नःश क पमा उपल ध छ । फोन गनहोसरु ः्‍ 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 ኣማርኛ 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 무료로이용하실 수있습니다. 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 800-305-9673 (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).

Section J

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 1-800-3681019, 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.

Before you turn this application in, did you….

1) Include any requested items or verifications listed throughout the application?

2) Sign and date below?

By signing below, I agree:

- I understand that any false statements which I may make and any failure on my part to report any change in circumstance which would affect my eligibility for payment from programs administered by the South Dakota Department of Social Services constitutes a crime and that I could be prosecuted under South Dakota criminal laws.
- I agree to provide information upon request from the Department of Social Services concerning any asset or estate which may be subject to recovery, estate recovery, or medical assistance liens by the State of South Dakota.

AUTHORIZATION TO FURNISH AND RELEASE INFORMATION

I hereby authorize any person, agency, or institutions to supply information requested by the Department of Social Services concerning me or my family and allow inspection and reproduction of the records in his or their possession pertaining to me or my family by any duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

This authorization is given only in connection with its use by the Department in the administration of its programs and for no other purpose. It shall continue in effect until such time as I state in writing that it is no longer valid.

I therewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

____

Printed name of your child for whom you have completed this application

____

Signature of parent, guardian, or authorized representative **Date**

____

Printed name of individual who signed above **Relationship to participant/patient**

If signed by a personal representative, provide verification of the representative's authorization to act for the participant/patient.