

South Dakota Application for Medicare Savings Program

NOTE: This application **CAN** be used for a single person or a couple (self and spouse).

This is **NOT** an application for full Medicaid, cash assistance, or the Supplemental Nutrition Assistance Program. If you want more information on these programs, please check below.

- Supplemental Nutrition Assistance Program Sales Tax on Food Refund
 Low Income Energy Assistance

1. INSTRUCTIONS:

<p>Read this application carefully and follow all instructions given throughout the form.</p> <ol style="list-style-type: none"> 1. Answer each question completely and accurately. Attach additional pages if needed. 2. If you need help completing or understanding this form, contact the Department of Social Services in the county where you live. 3. Include copies of all documents that are available to you. Do not send original documents. 4. Sign and date the application. 5. Mail the application to your local Social Services Office. 6. An interview is not required for these programs. 	<p style="text-align: center; font-weight: bold;">AGENCY USE ONLY</p> <p>Case No. _____</p> <p>Date Received _____</p> <p>Recipient ID _____ _____</p>
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Are you interested in possible eligibility for the prior three months? **Yes** **No**
 If yes, provide proof of income and verifications of resources from those months.

2. PERSONAL INFORMATION: Completion of Race, Social Security Number (SSN), and citizenship is optional for persons NOT requesting assistance.

Name (Last, First, Middle Initial)	Race(can check more than one) () White () American Indian () Black () Hawaiian () Asian	Ethnicity Also check here if Hispanic ()
Birthdate Sex Marital Status	If someone else is completing this form, provide the following information for the individual completing the form.	
Social Security Number U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Name (Last, First, Middle Initial)	
Street Address	Street Address	
City State Zip	City State Zip	
Phone County	Phone	
Nursing Facility (if applicable)	Relationship to Individual	

3. INFORMATION ON SPOUSE: Complete this information even if not applying for spouse.

		*Completion is optional if NOT requesting assistance.			
Spouse's Name	Birthdate	Sex*	Race*	U.S. Citizen*	Social Security Number*
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Address of Spouse if Different from Applicant:					
Are you applying for Medicare Savings for your spouse, too? <input type="checkbox"/> Yes <input type="checkbox"/> No					

4. INFORMATION ON DEPENDENTS LIVING WITH APPLICANT(S):

Name of Dependent	Birthdate	Relationship

5. INFORMATION ON MEDICARE:

Attach **copies** (front and back) of Medicare card(s) if you, or your spouse, have Medicare.

Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check Each Box that Applies) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Effective Date	Medicare ID Number
Part D Plan Name: _____			
Does your spouse have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check Each Box that Applies) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Effective Date	Medicare ID Number
Part D Plan Name: _____			

6. INFORMATION ON OTHER INSURANCE:

Do you have other health insurance? Yes No

Does your spouse have other health insurance? Yes No

If you, or your spouse, have other insurance, please complete the following information and attach proof of insurance, such as an insurance card (front & back) or statement of benefits, to this application.

	Health Insurance Company Name and Company Address	Annual Premium	Type of Coverage (Hospital, Medigap, RX)	Effective Date	Policy Number
Self		\$			
Spouse		\$			

7. INCOME AND EARNINGS: Attach Proof of Income to Application

List all types of earnings and income that you, your spouse, or dependent(s) receive. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stubs, benefit letter, etc.). **Do not send original documents.** Examples of income include:

- * Social Security
- * Railroad Retirement Benefits
- * Pensions/ Retirement Benefits
- * Civil Service Annuity
- * Life Estate Income
- * BIA General Assistance
- * SSI
- * Veteran’s Benefits
- * Rental/Lease Income
- * Insurance Payments
- * Support Payments
- * IIM Lease Income
- * Wages/ Self-Employment
- * Trust or Annuity Payments
- * Oil/Mineral/Timber Rights
- * IRA/KEOGH/401K Payments
- * Payments on Contract for Deed
- * Contributions from Others

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	Date Paid

8. PROPERTY:

Do you or your spouse own all or part of any real estate? Yes No

If yes, please complete the following for each piece of real estate.

Address	Value	Amount Owed

Do you or your spouse own a car, truck, motorcycle, boat, trailer, camper or other vehicle?

Yes No If yes, please complete the following information about each vehicle:

Owner(s)	Year	Make	Model	Value	Amount Owed

9. RESOURCES: Attach Verification of Resources to Application

List all types of resources (assets) owned by you or your spouse. Include any accounts or properties on which you or your spouse's name(s) appear. Include verification (such as copies, not originals, of your most recent bank statement, trust funds, etc) of all resources. Examples of resources:

- *Checking accounts *Funeral plans/ burial arrangements *Cash on Hand
- *Savings accounts *Burial plots *Safety Deposit Box
- *Government bonds *Stocks/Bonds/Mutual Funds *Retirement Funds
- *Trust Funds *Certificate of Deposit *Life Estate
- *Annuities *Business Equipment, Machinery, etc *Property Rights (mineral/timber)

Attach additional pages if necessary.

If you and/or your spouse have no resources check here.			<input type="checkbox"/> None
Type of Resource	Account Number	Value	Name of Bank, Financial Institution, Etc.

10. LIFE INSURANCE: Attach Verification of Cash Value of Policy

Do you, or your spouse, have a life insurance policy? Yes No

If yes, please complete the following information.

Policy Owner	Insurance Company Name and Address	Policy Number	Face Value	Cash Value

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party that may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

ESTATE RECOVERY AND MEDICAL ASSISTANCE LIENS:

NOTE: Medicare co-payments, co-insurance, deductibles and premiums paid through the Qualified Medicare Beneficiary (QMB) program on or after January 1, 2010 are not subject to recovery from the estate of a deceased individual.

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased QMB recipients for cost-sharing benefits received prior to January 1, 2010. Medicare co-payments and deductibles paid through the QMB program prior to January 1, 2010 are subject to estate recovery only if the recipient received any of the following services: Nursing facility, Home-Community Based Services (if over age 55), Intermediate Care Facility for the Mentally retarded (ICF/MR) and Hospital (in-patient and out-patient). This recovery is only on the amount that Medicaid expended for the above services on behalf of the QMB recipient. There is no recovery for physician or clinic 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 a liable 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 for the above services on behalf of the applicant. The petition must be filed on the Department's form.

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 medical facility if the resident was receiving medical assistance from the Department at the time of death.

APPLICANT’S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and a review of any agency records. I also agree that my application authorizes these agencies to release to the Department of Social Services the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which the Department of Social Services may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand I have the right to request a fair hearing if my application is not acted upon within 45 days of the application. I understand I may also request a fair hearing if I believe the Department made an incorrect decision regarding my application and that such request must be made within 30 days of the written notice informing me of the department’s decision. I understand that I may be represented by any person I choose. To request a hearing, send a signed, written request to the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre, SD 57501-2291. The request must indicate what action is being appealed.

Any person who feels that his civil rights have been violated may request a fair hearing. You may also file a complaint of discrimination by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or by calling (605) 773-3305.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify the Department of Social Services of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	Date:
Signature of Applicant’s Spouse:	Date: