

South Dakota Children and Family Medical Assistance Application

Visit our website: dss.sd.gov/medicaleligibility

Who should complete this application?

This application is used to determine if you and/or your family members are eligible for health care coverage for the following medical assistance programs:

- **Families with dependent children (Low Income Families)**

The Low Income Families medical program provides health care to families with dependent children. To be eligible, the family must consist of a parent/stepparent or other relative caretaker and a dependent child. A relative caretaker includes, but is not limited to, a grandparent, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew, or cousin of a dependent child. A dependent child is a child under age 18 who is living with a parent or a relative caretaker. If a child is 18 years old and still a fulltime student in high school, the child is considered a dependent child if s/he is expected to complete high school before reaching age 19.

- **Children under the age of 19 (Children's Health Insurance Program)**

The South Dakota Children's Health Insurance Program (CHIP) provides health care for children and teenagers. To be eligible for CHIP, children must be under the age of 19 and be residents of South Dakota. Children who are uninsured or already have health insurance may be eligible for CHIP.

- **Pregnant women**

The Department of Social Services provides medical assistance to pregnant women. Pregnant women may qualify for limited coverage or full coverage.

- Limited Medical Coverage for Pregnant Women provides limited medical coverage to pregnant women. The income and resource limits are higher than the Full Medical Coverage for Pregnant Women program.
- Full Medical Coverage for Pregnant Women provides full medical coverage to pregnant women. The income and resource limits are lower than the Limited Medical Coverage for Pregnant Women Program.

Additional information regarding all medical assistance programs, including income guidelines and applications for the Medicare Savings Program and Long Term Care programs can be found on our website at dss.sd.gov/medicaleligibility.

What services are covered?

Unless otherwise stated, coverage includes, but is not limited to doctor visits; inpatient and outpatient hospitalizations; dental and vision services; prescription drugs; mental health care; routine preventive services, such as check ups and immunizations; chiropractic services; family planning; prenatal care; and other medical services may be covered.

Limited Medical Coverage for Pregnant Women provides coverage for prenatal and pregnancy-related services, including delivery and includes 60 days postpartum care and family planning services.

For additional information regarding covered services, please visit our website at <http://dss.sd.gov/sdmedx/includes/recipients/covered/index.aspx>.

I am not sure if I qualify for medical assistance. Should I complete an application?

Yes, we encourage you to complete an application whenever you think you might be eligible for medical assistance. We are unable to determine your eligibility without a completed and signed application.

How do I apply for Medical Assistance?

Step 1 – Complete all the sections in green the best you can. If more space is needed, please use a separate sheet of paper.

If more than one family lives in your home, each family requesting medical assistance must fill out a separate application. A relative caretaker, caring for a dependent child, may request medical assistance for his/herself.

If the child(ren)'s parents/stepparents are not living in the home and the relative caretaker is not requesting medical assistance, a separate household may be established for the child(ren). In this case, only the child(ren)'s information is required for questions 2 through 18 on the attached application (skip questions 19-22 of the application).

Step 2 – Sign and date the application on Page 8. We are unable to process your application unless you sign and date the application.

Step 3 – Provide documentation. You may send in your application right away even if you do not have all required documentation. Social Services will let you know which documentation you will need to send to them. Note: Sending the documentation with the application will speed up the time it takes to decide if you and your family members are eligible for medical assistance.

Step 4 – Mail, fax, or take your application to a local Social Services office. You do not have to go to a Social Services office to apply for medical assistance.

Step 5 - If you have any questions or need assistance, please contact your local Social Services' office (contact information for Social Services' offices can be found at the end of this document).

How and when will I know if I am eligible?

Your application will be reviewed as soon as possible. The start date of medical assistance depends on the date the application is received in the Social Services office. You should receive a written decision within 45 days from the date this form is received in the Social Services office. If you have not received a notice within 45 days, please contact your local Social Services office.

Where can I find additional information regarding other Social Services programs?

Information regarding other Social Services' programs can be found on our website at dss.sd.gov. Other programs include, but are not limited to:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Child Care Services
- Child Support Services
- Energy and Weatherization Assistance

If you would like to apply for or receive more information about programs and services offered by the Department of Social Services, you may contact the Social Services office nearest you. See attached list of offices at the end of this document.

(Keep this page for your records)

(GO TO NEXT PAGE TO BEGIN COMPLETING THE APPLICATION)

DSS USE ONLY: Date Received: _____ Case Number: _____ Section 1

South Dakota Children and Family Medical Assistance Application

Citizenship and Identification

Citizenship and Identification

U.S. Citizens/Nationals asking for Medical Assistance must have **citizenship** and **identity** verified. The Department of Social Services will attempt to verify citizenship and identity for all U.S. Citizens/National requesting medical assistance. The Department of Social Services will notify you if documentation is required to verify citizenship and/or identity.

Qualified aliens who are requesting medical assistance **must provide documents to verify their alien status and identity.** All documents must be originals or copies certified by the issuing agency. Documents presented for this purpose will be returned. Examples of documents for identity verification are: current driver's license; ID card used by a federal, state, tribal or local government agency; school ID with photograph; and for children age 16 or younger, clinic, doctor, or hospital records, or school records.

Tell us about you.

1. List the primary contact person for the household. If you are applying for children only, a parent, guardian, or adult household member should be listed as the primary contact person for the household.

First Name	Middle Initial	Last Name
Home Telephone	Work Telephone	Cell Phone
Street Address		Apartment Number
City	State	Zip Code
Mailing Address (if different from street address)		
What is your primary language (check one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, please specify _____		
If you do not speak English and need assistance completing this application, please contact your local Social Services office. Si usted no habla Ingles y necesita ayuda para completar esta aplicacion, por favor contacte su oficina local the Seguro Social.		

Tell us about individuals living in your home.

2. Include the following individuals below:

- **Dependent children living in the home.** A dependent child is a child under age 19 living with their parent(s)/stepparent or caretaker relative. **NOTE:** Children under age 19 temporarily out of the home may be eligible for medical assistance, include these children below.
- **Parents and stepparents.** Parents and stepparents living in the home with dependent children requesting medical assistance.
- **Relative caretaker.** A relative caretaker includes, but is not limited to, a grandparent, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew, or cousin of a dependent child requesting medical assistance.
- **Spouses of: pregnant women, relative caretakers, dependent children living in the home requesting medical assistance.**

Completion of Social Security number and citizenship is optional for those not asking for medical assistance. Completion of race and ethnicity is optional.

First Name, Middle Initial, Last Name	Indicate If Requesting Medical Assistance Circle One	Relationship To Person Filling Out This Form <small>(Example: self, child, stepchild, grandchild, niece, nephew, first cousin, friend)</small> SELF	Social Security Number	Birth Date	Sex Circle One	Marital Status Circle One	Race (Optional) May Circle More Than One	Are You Hispanic Or Latino (Optional) Circle One	U.S. Citizen Circle One
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No

**Completion of Social Security number and citizenship is optional for those not asking for medical assistance.
 Completion of race and ethnicity is optional.**

First Name, Middle Initial, Last Name	Indicate If Requesting Medical Assistance Circle One	Relationship To Person Filling Out This Form <small>(Example: Self, Child, stepchild, grandchild, niece, nephew, first cousin, friend)</small>	Social Security Number	Birth Date	Sex Circle One	Marital Status Circle One	Race (Optional) May Circle More Than One	Are You Hispanic Or Latino (Optional) Circle One	U.S. Citizen Circle One
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No
	Yes No				Male Female	Single Married Divorced Widowed	White American Indian/ Alaska Native Black Hawaiian/Pacific Islander Asian	Yes No	Yes No

3. If you are **not** a parent/stepparent to a child(ren) requesting medical assistance, are you a legal guardian to the child(ren)? (“Legal Guardian” means a person appointed by a court to make decisions regarding the support, care, education, health or welfare of an individual). You are not required to be a legal guardian to apply for medical assistance for yourself or a child(ren).

Yes No N/A

4. Are you or any other family members pregnant? Unborn children may be counted in the family.

Yes No (If Yes, list below; If No, skip to question 6.)

Pregnant Woman First Name, Middle Initial, Last Name	Expected Due Date And Number Of Babies Expected
	Expected Due Date: _____ Number of Babies Expected: _____
	Expected Due Date: _____ Number of Babies Expected: _____

5. Is there a plan for surrogacy or adoption?

Yes No (If there is a plan for surrogacy or adoption, provide any agreement regarding coverage of medical expenses).

6. Did any family members requesting medical assistance have unpaid medical bills in the last three months, or did a pregnant woman requesting medical assistance receive medical services in the last three months?

Yes No (If Yes, list below)

There may be eligibility for medical assistance for prior months if you and/or a family member received health care services (including medical, dental, vision, etc.) in the three months before your application was received by the Department of Social Services.

Please provide documentation of income from the month(s) when the medical service(s) was received.

First Name, Middle Initial, Last Name	Month(s) Of Medical Bill(s)

7. Are any family members covered by health insurance other than Medicaid/CHIP?

Yes No (If Yes, list below)

Attach documentation of other insurance. Documentation can be a copy of the insurance card (front and back) or a statement of benefits. Include insurance from a foreign country.

Person(s) Covered	Policy Holder	Employer Name and Name of Insurance Co.	Check Type Of Insurance	Group #/ Policy #	Start Date/ End Date
			<input type="checkbox"/> Vision <input type="checkbox"/> Accident <input type="checkbox"/> Inpatient <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Pharmacy <input type="checkbox"/> Work Comp <input type="checkbox"/> Other If Other, please specify: _____	Group # _____ Policy # _____	Start Date: _____ End Date: _____
			<input type="checkbox"/> Vision <input type="checkbox"/> Accident <input type="checkbox"/> Inpatient <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Pharmacy <input type="checkbox"/> Work Comp <input type="checkbox"/> Other If Other, please specify: _____	Group # _____ Policy # _____	Start Date: _____ End Date: _____
			<input type="checkbox"/> Vision <input type="checkbox"/> Accident <input type="checkbox"/> Inpatient <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Pharmacy <input type="checkbox"/> Work Comp <input type="checkbox"/> Other If Other, please specify: _____	Group # _____ Policy # _____	Start Date: _____ End Date: _____

8. Are any family members, living in your home, covered or eligible for coverage under the South Dakota State Employees insurance program?

Yes No; If yes, please list who is covered or eligible: _____

9. Have any family members voluntarily dropped group health insurance within the past 3 months?

Yes No; If yes, what was the reason for dropping the insurance? _____

Tell us about income.

10. Are any family members receiving income from a job?

Yes No (If Yes, list below)

Examples of income from a job include: Wages, Bonuses, Wage Advances, Tips, Vacation/Sick Pay, and Severance Pay

Do not include wages of dependent children under age 19.

Do not include wages of a non-parent caretaker if s/he is not requesting medical assistance for her/himself.

Please attach documentation of gross income. Documentation of income should include copies of pay stubs or a letter from the employer showing income from each job for the last 30 days.

First Name, Middle Initial, Last Name	Name Of Employer	Hours Per Week And Wage Per Hour	Gross Income (Before Deductions)	How Often Received?	Has This Job Ended? If Yes, Indicate Date Ended.	When Is the Next Pay Date?
		Hours per week: _____ Wage per hour: \$ _____/hr.	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> twice monthly <input type="checkbox"/> monthly <input type="checkbox"/> other	Yes No If yes, date ended _____	
		Hours per week: _____ Wage per hour: \$ _____/hr.	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> twice monthly <input type="checkbox"/> monthly <input type="checkbox"/> other	Yes No If yes, date ended _____	
		Hours per week: _____ Wage per hour: \$ _____/hr.	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> twice monthly <input type="checkbox"/> monthly <input type="checkbox"/> other	Yes No If yes, date ended _____	

11. Are any changes expected in income from a job (i.e., beginning or ending a job, change of hours, etc.)?

Yes No If yes, explain: _____

12. Are any family members receiving income from self-employment?

Yes No (If Yes, list below)

Do not include income from self-employment of dependent children under age 19.

Do not include income from self-employment of a non-parent caretaker if s/he is not requesting medical assistance for her/himself.

Please provide copies of the most recent tax forms (provide the entire form). The tax forms must be signed. Business ledgers or office records will be needed if you do not have tax forms.

First Name, Middle Initial, Last Name	Type Of Work

13. Are any changes expected in income from self-employment (i.e., beginning or ending self-employment, significant change in self-employment)?

Yes No If yes, explain: _____

14. Are any family members receiving income other than from a job or self-employment?

Yes No (If Yes, list below)

Examples include: Child/Spousal Support; Social Security; Supplemental Security Income (SSI); BIA General Assistance; Tribal TANF; Unemployment; Worker's Compensation; Veteran's Benefits; Retirement; Pensions; Annuities; Strike Benefits; Dividends; Rental Income; Trusts; Tribal Lease or Per Capita Income; Prizes; Money from Family or Friends; Interest Income; or Military Allotment.

Include income (other than from a job or self-employment) of children.

Do not include income of a non-parent caretaker if s/he is not requesting medical assistance for her/himself.

Please provide documentation of income.

First Name, Middle Initial, Last Name	Source Of Income	Gross Amount – Before Deductions	How Often Received?
		\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/> other
		\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/> other

15. Are any changes expected in income that are not from a job or self-employment?

Yes No If yes, explain: _____

Tell us about childcare or child support expenses.

Providing this information may help make you eligible.

16. Do any family members have childcare expenses due to employment?

Yes No (If Yes, list below)

Please provide documentation of childcare paid due to a job or self-employment. Documentation can be bills or a statement from the childcare provider. Do not list childcare paid by the South Dakota Child Care office or childcare assistance paid by some other source; only list amount actually paid.

Name(s) of Child(ren) To Whom Childcare Is Being Provided First Name, Middle Initial, Last Name	Amount Paid	How Often Paid?	Name(s) Of Childcare Provider/Facility
	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/> other	
	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/> other	

17. Are changes expected in childcare paid (i.e., beginning or ending of childcare paid, amount paid increasing or decreasing)?

Yes No If yes, explain: _____

18. Do any family members pay court ordered child support to another household?

Yes No (If Yes, list below)

Please provide documentation of child/spousal support paid to another household. NOTE: If you pay child support to the South Dakota Child Support office, you do not need to provide documentation.

First Name, Middle Initial, Last Name Of Person Who Pays Child Support	Amount Paid	How Often Paid?	First Name, Middle Initial, Last Name Of Person Child Support Is Paid To
	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/> other	
	\$	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/> other	

Tell us about resources.

19. Are you asking for medical assistance for a pregnant woman, parent/stepparent or relative caretaker?

Yes No (If Yes, continue to question 20; If No, skip to next page)

20. Do any family members, including children, own or co-own any cars, trucks, boats, campers, motorcycles, snowmobiles, trailers, or ATV's?

Yes No (If Yes, list below)

Owner/Co-owner	Year	Make (Ford, Chevy, Etc.)	Model (Taurus, Blazer, Etc.)	Amount Owed	Is Vehicle Leased?
				\$	Yes No
				\$	Yes No
				\$	Yes No

21. Do any family members, including children, own or co-own any land, buildings, livestock, farm equipment, or other property? Do not include the house you live in.

Yes No (If Yes, list below)

Owner/Co-owner	Type of Resource	Value	Amount Owed	For Sale? Rental?
		\$	\$	For Sale? Yes No Rental? Yes No
		\$	\$	For Sale? Yes No Rental? Yes No
		\$	\$	For Sale? Yes No Rental? Yes No

22. Do any family members, including children, own/co-own any other resources?

Yes No (If Yes, list below)

Examples include: Cash; Checking; Savings; Credit Union; Stocks; Bonds; Certificates of Deposit; Whole Life Insurance (not Term Life Insurance); Trust Funds; Individual Indian Monies (IIM); Money Market Funds; Deferred Compensation Plan; Burial Funds; Contracts for Deed; IRAs; 401K; Keogh plan; Safe Deposit Box; or other items of value.

Owner/Co-owner	Type Of Resource	Name And Address Of Resource Location	Account Number, If Applicable	Value/ Balance
				\$
				\$
				\$

Protections, Consents and Signatures

Signing this form means that I understand the following protections:

Information on this form is confidential and can only be used as necessary to determine eligibility and administer the programs.

I understand I have the right to request a fair hearing if my application is not acted upon within 45 days after the application is received in the DSS office. I may also request a fair hearing if I believe the agency made an incorrect decision regarding my application within 30 days from the date I receive a written notice. To request a fair hearing, send a signed, written request to the Office of Administrative Hearings, Department of Social Services, 700 Governor's Drive, Pierre, SD 57501. The request must indicate what action is being appealed.

No person can be denied benefits because of race, color, national origin, gender, religion, age, disability, or political belief. To file a complaint of discrimination, write DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501 or call (605) 773-3305.

Read the following section carefully

Signing this form means that I consent to the following:

- I understand to correctly determine eligibility, information may be computer matched through Social Security number with the IRS, Social Security Administration, US Department of Labor, other governmental agencies or private financial institutions.
- I authorize the Department of Social Services to release information to providers, State or Federal agencies. This consent is given only for use by the Department in administration of its program.
- I give my consent for any person, agency or institution to supply information to the Department of Social Services about me or my family and to allow inspection and copying of records about me or my family by any representative of the Department. I release any person, agency or institution from any legal responsibility to me or my family for supplying such information.
- I understand that an 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 or recipient's care.
- I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I understand I will be required to repay any benefits that are paid to me or on my behalf because of incorrect or false information or failing to report changes to this form. I understand that if any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

Signatures are needed to process your application

Your Name (Primary contact person for the household)
(Please Print)

Your Signature (Primary contact person for the household)

Today's Date

Department of Social Services Offices
(You may keep this page for your records)

Visit our website: dss.sd.gov/medicaleligibility

Aberdeen
 (Brown County)
 3401 10th Ave, SE, 57401
 Fax: 605-626-2610
 Local Number: 605-626-3160
 Toll Free: 1-866-239-8855

Armour*
 (Douglas County)
 (Contact Lake Andes Office)
 1st and 2nd Thursday (8 -5)

Belle Fourche
 (Butte County)
 609 5th Avenue 57717-1405
 Fax: 605-892-3616
 Local Number: 605-892-2731
 Toll Free: 1-877-390-0096

Britton*
 (Marshall County)
 (Contact Sisseton Office)
 1st and 3rd Wednesdays (8-4:30)

Brookings
 (Brookings County)
 1310 Main Avenue, S., Suite 101
 57006-3893
 Fax: 605-688-4339
 Local Number: 605-688-4330
 Toll Free: 1-866-267-5228

Buffalo*
 (Harding County)
 (Contact Belle Fourche Office)
 2nd Tuesday (10-4)

Burke
 (Gregory County)
 Gregory County Courthouse
 221 E 8th St.
 Po Box 186, 57523-0186
 Fax: 605-7759121
 Local Number: 605-775-2683
 Toll Free: 1-877-842-8438

Canton**
 (Lincoln County)
 104 N Main St., Suite 140
 57013-1796
 Fax: 605-987-3076
 Local Number: 605-764-5761
 Toll Free: 1-866-343-0753

Chamberlain
 (Brule County,
 also serves Lyman County)
 320 Sorenson Dr., 57325-1022
 Fax: 605-734-4505
 Local Number: 605-734-4500
 Toll Free: 1-888-749-0007

Clark*
 (Clark County)
 (Contact Watertown Office)
 1st Tuesday (9-3)

Clear Lake*
 (Deuel County)
 (Contact Watertown Office)
 3rd and 4th Wednesdays (9-3)

Custer
 (Custer County)
 1164 Mt. Rushmore Road, #3
 57730-2133
 Fax: 605-673-2070
 Local Number: 605-673-4347
 Toll Free: 1-877-763-0006

Deadwood
 (Lawrence County)
 20 Cliff Street
 PO Box 607, 57732-0607
 Fax: 605-578-1280
 Local Number: 605-578-2402
 Toll Free: 1-877-268-0007

DeSmet*
 (Kingsbury County)
 (Contact Brookings Office)
 1st and 3rd Tuesdays (9-3)

Dupree*
 (Ziebach County)
 (Contact Eagle Butte Office)
 Tuesdays and Thursdays (8-5)

Eagle Butte
 (Dewey County)
 1302 N Willow
 PO Box 530, 57625-0530
 Fax: 605-964-1200
 Local Number: 605-964-4484
 Toll Free: 1-866-480-0201

Elk Point
 (Union County)
 118 West Main
 PO Box 520, 57025-0520
 Fax: 605-356-3683
 Local Number: 605-356-3346
 Toll Free: 1-866-486-0016

Faulkton*
 (Faulk County)
 (Contact Redfield Office)
 1st Wednesday (9:30-3:30)

Flandreau*
 (Moody County)
 (Contact Sioux Falls Office)
 Tuesdays and Thursdays (8:30-4:30)

Fort Thompson*
 (Buffalo County)
 (Contact Chamberlain Office)
 1st Wednesday (9:30-3:30)

Gettysburg*
 (Potter County)
 (Contact Mobridge Office)
 1st Thursday (9-2)

Hayti*
 (Hamlin County)
 (Contact Watertown Office)
 Every Thursday (8-4)

Highmore*
 (Hyde County)
 (Contact Pierre Office)
 1st Thursday (9-3)

Hot Springs
 (Fall River County)
 2500 Minnehahata Ave, Bldg. #1
 PO Box 729, 57747-0729
 Fax: 605-745-6562
 Local Number: 605-745-5100
 Toll Free: 1-888-747-0039

Howard*
 (Miner County)
 (Contact Madison Office)
 1st and 3rd Tuesdays (8-4:30)

Huron
 (Beadle County)
 110 Third St. S.W., Suite 200
 57350-2450
 Fax: 605-353-7103
 Local Number: 605-353-7100
 Toll Free: 1-877-329-0019

Ipswich*
 (Edmunds County)
 (Contact Aberdeen Office)

Kadoka*
 (Jackson County)
 (Contact Martin Office)
 1st Friday (9-3)

Kyle*
 (Shannon County)
 (Contact Pine Ridge Office)
 Every Tuesday and Thursday (9-3)

Lake Andes
 (Charles Mix County)
 3rd & Lake
 PO Box 190, 57356-0190
 Fax: 605-487-7429
 Local Number: 605-487-7607
 Toll Free: 1-877-656-0023

Lemmon*
 (Perkins County)
 (Contact McIntosh Office)
 Every Thursday (9-3)

Leola*
 (McPherson County)
 (Contact Aberdeen Office)

Madison
 (Lake County)
 223 S. Van Eps Ave., Suite 201
 57042-2855
 Fax: 605-256-5043
 Local Number: 605-256-5683
 Toll Free: 1-877-412-0022

***Indicates Itinerant office**

Martin

(Bennett County)
 404 3rd Ave
 PO Box 250, 57551-0250
 Fax: 605-685-6652
 Local Number: 605-685-6526
 Toll Free: 1-866-416-0094

McIntosh

(Corson County,
 also serves Perkins County)
 185 Main Street
 PO Box 108, 57641-0108
 Fax: 605-273-4322
 Local Number: 605-273-4513
 Toll Free: 1-800-748-2380

Milbank

(Grant County)
 Grant County Courthouse
 210 E. 5th Avenue
 PO Box 1024, 57252-1024
 Fax: 605-432-9563
 Local Number: 605-432-9588
 Toll Free: 1-866-486-0028

Miller*

(Hand County)
 (Contact Redfield Office)
 1st and 3rd Tuesdays (9:30-3:30)

Mission

(Todd County)
 671 N. Marge Lane
 PO Box 818, 57555-0818
 Fax: 605-856-2031
 Local Number: 605-856-4489
 Toll Free: 1-888-280-0021

Mitchell

(Davison County,
 also serves Hanson County)
 116 E. 11th Avenue, 57301-1432
 Fax: 605-995-8929
 Local Number: 605-995-8000
 Toll Free: 1-800-231-8346

Mobridge

(Walworth County,
 also serves Campbell
 County)
 920 6th Street W
 PO Box 160, 57601-0160
 Fax: 605-845-7126
 Local Number: 605-845-2922
 Toll Free: 1-877-431-3978

Murdo*

(Jones County)
 (Contact White River Office)
 (As needed or by appointment)

Olivet

(Hutchinson County)
 Hutchinson County Courthouse
 140 Euclid, Room 127
 57052-2103
 Fax: 605-387-2438
 Local Number: 605-387-4219
 Toll Free: 1-877-454-0074

Parker

(Turner County)
 Turner County Courthouse
 400 S. Main
 PO Box 339, 57053-0039
 Fax: 605-297-3201
 Local Number: 605-297-3251
 Toll Free: 1-866-610-0093

Philip*

(Haakon County)
 (Contact Pierre Office)
 1st Monday (9-3)

Pierre

(Hughes County,
 also serves Sully County and
 Stanley County)
 912 East Sioux, 57501-3490
 Fax: 605-773-5390
 Local Number: 605-773-3612
 Toll Free: 1-800-226-1033

Pine Ridge

(Shannon County)
 Hwy 18, Airport Access Road
 PO Box 279, 57770-0279
 Fax: 605-867-1263
 Local Number: 605-867-5861
 Toll Free: 1-877-899-0020

Plankinton*

(Aurora County)
 (Contact Mitchell Office)
 1st and 3rd Thursday (9:30-3:30)

Rapid City

(Pennington County)
 510 N. Cambell
 PO Box 2440, 57709-2440
 Fax: 605-394-1969
 Local Number: 605-394-2525
 Toll Free: 1-800-644-2914

Redfield

(Spink County)
 Spink County Courthouse
 210 E 7th Avenue, 57469-1299
 Fax: 605-472-4298
 Local Number: 605-472-2230
 Toll Free: 1-877-372-0010

Salem

(McCook County)
 McCook County Courthouse
 130 W Essex
 PO Box 178, 57058-0178
 Fax: 605-425-2064
 Local Number: 605-425-2271
 Toll Free: 1-888-203-1797

Sioux Falls**

(Minnehaha County)
 811 E 10th Street, Dept. #1
 57103-1650
 Fax: 605-367-5473
 Local Number: 605-367-5444
 Toll Free: 1-866-801-5421

Sisseton

(Roberts County)
 119 E Cherry St
 PO Box 230, 57262-0230
 Fax: 605-698-7842
 Local Number: 605-698-7673
 Toll Free: 1-888-747-0017

Sturgis

(Meade County)
 2200 W. Main Street
 57785-1338
 Fax: 605-347-3767
 Local Number: 605-347-2588
 Toll Free: 1-888-476-0036

Timber Lake*

(Dewey County)
 (Contact Eagle Butte Office)
 Every Tuesday (8-5)

Tyndall

(Bon Homme County)
 103 W 18th Avenue
 PO Box 2, 57066-0002
 Fax: 605-589-4309
 Local Number: 605-589-4319
 Toll Free: 1-888-203-1311

Vermillion

(Clay County)
 114 Market Street, 57069
 Fax: 605-677-6808
 Local Number: 605-677-6800
 Toll Free: 1-800-730-0153

Wanblee*

(Jackson County)
 (Contact Martin Office)
 Every Monday & Wednesday
 (9-3)

Watertown

(Codington County)
 2001 9th Avenue, SW, Suite 300
 57201-4029
 Fax: 605-882-5045
 Local Number: 605-882-5000
 Toll Free: 1-866-239-6787

Webster*

(Day County)
 (Contact Aberdeen Office)
 Tuesdays (& Thursdays (8-4:30))

Wessington Springs*

(Jerauld County)
 (Contact Mitchell Office)
 1st and 3rd Tuesdays (9:30-3:30)

White River

(Mellette County)
 Mellette County Courthouse
 321 E 4th Street
 PO Box 219, 57579-0219
 Fax: 605-259-3202
 Local Number: 605-259-3101
 Toll Free: 1-888-285-0033

Winner

(Tripp County)
 649 W Second Street
 PO Box 31, 57580-0031
 Fax: 605-842-2574
 Local Number: 605-842-0400
 Toll Free: 1-866-913-0031

Woonsocket*

(Sanborn County)
 (Contact Mitchell Office)
 1st and 3rd Wednesday (9:30-3:30)

Yankton

(Yankton County)
 3113 Spruce Street, Suite 200
 57078-5320
 Fax: 605-668-3014
 Local Number: 605-668-3030
 Toll Free: 1-800-455-5241

*Indicates Itinerant office

**If you have a mailing address of
 Harrisburg or Tea, you may
 contact Canton or Sioux Falls