HARDSHIP CONSIDERATION (Calendar Year 2021)

Instructions

Please read all questions carefully. All "yes" answers must include a detailed explanation and appropriate documentation (attach additional pages as needed). Return the completed form to the Behavioral Health Provider within 30 days of the initial ineligibility determination. The Division of Behavioral Health will make a determination on eligibility within 30 days of receiving the completed form and necessary verifications from the Behavioral Health Provider.

Personal Information *(Please Print)*

CID #: _____

Client Name: _____
(First) *(MI)* *(Last)*

Address: _____ Ph. #: _____
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):_____

Address (if different from above): _____

☐ **YES** ☐ **NO** Are you responsible for the care of an extended family member not residing in your home? Please list whose care you are responsible for, their expenses and average cost per year.

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☐ **YES** ☐ **NO** Do you have outstanding medical debt? Please describe and include supporting documentation.

_____

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☐ **YES** ☐ **NO** Do you have debt from prior mental health or substance use services? Please describe and include supporting documentation.

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☐ **YES** ☐ **NO** Do you have debt from prior gambling services or debts related to your gambling addiction? Please describe and include supporting documentation.

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☐ **YES** ☐ **NO** Have you had any unforeseen or uncontrollable expenses (other than medical or treatment expenses)? Please describe and include supporting documentation.

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☐ **YES** ☐ **NO** Does anyone in your household have a medically determined mental or physical impairment? Please list the individual and the impairment. Describe the expenses related to the individual's impairment and average cost per year.

_____

_____

☐ **YES** ☐ **NO** Do you have a medically determined mental or physical impairment? Please describe your impairment, the expenses related to your impairment and the average cost per year.

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☐ **YES** ☐ **NO** Do you have extraordinary housing costs (e.g., paying rent during hospitalization, paying two mortgages)? Please explain and provide supporting documentation.

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☐ **YES** ☐ **NO** Do you have excessive transportation costs? Please explain and provide an overage cost per year.

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☐ **YES** ☐ **NO** Is there any other expense that would make paying for your behavioral health services an undue financial burden (e.g. credit card debt, personal loans, student loans)? Please explain and provide supporting documentation.

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I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report change in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services.

_____

Signature (Client or Parent/Guardian) Date

Non-Discrimination Statement

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).