South Dakota Indigent Medication Program
New Application

The Department of Social Services Division of Behavioral Health will use this information to determine eligibility for temporary coverage of psychotropic/alcohol cessation/ substance use medications and/or related laboratory work. Applications will be processed within **5 business days** after completed application is received. Please use the fillable form or print clearly.

The entire application must be completed, or it will not be processed.

Date: _____

Applicant Information:

Applicant Name: _____
First *MI* *Last*

Date of Birth: _____ Social Security Number (last 4 digits) XXX-XX-_____

Address: _____
Address *City* *State* *Zip Code*

Telephone Number: _____

Assistant Information:

If an agency is assisting with this application, please complete all contact information below.

Name (person assisting the client with the completion of this form): _____

Agency Name:_____

Email Address: _____

Phone Number: _____ Fax Number: _____

Incarceration:

Are you currently incarcerated? Yes ☐ No ☐

If yes, where? _____ Release date? _____

Financial Information:

Total Number of Persons Living in Household (dependent on household income): _____

Annual Gross Income: All sources of earned and unearned income for the household members included above. Do not include any income earned from a child under the age of 18 or any dependent attending school. *Please list income based on what you're currently receiving.

1) Earned Income *(i.e. wages)* $_____

2) Unearned Income *(i.e. child support, TANF, SSDI)* $_____

Minus Annual Deductions/Expenses:

3) $_____ Earned Income Deduction *(Deduct 20% of Earned Income. Do not deduct 20% from unearned income.)*

4) $_____ Childcare Expenses *(up to $6,000/year)*

5) $ _____ Child Support Payments

6) $_____ Annual out of pocket prescription medication costs and lab work.

7) $_____ Annual health insurance premiums.

8) $_____ Assistive devices purchased within the last 12 months.

*(describe)*_____

Annual Net Income:

9) $_____ *(deduct lines 3 through 8 from line 1 and 2)*

Employment:

Are you currently employed? Yes ☐ No ☐
If no, are you actively seeking employment? Yes ☐ No ☐ If no, why? _____

Other Income Sources:

Do you receive Social Security retirement benefits?
☐ Yes
☐ I have recently been approved but have not started receiving payments.
☐ No

Do you receive SSI (also known as Supplemental Security Income)?
☐ Yes
☐ I have recently been approved but have not started receiving payments.
☐ No, but I have applied for SSI and am waiting on a response.
☐ No, I have not applied.

Do you receive Social Security Disability benefits (also known as SSDI)?
☐ Yes
☐ I have recently been approved but have not started receiving payments.
☐ No, but I have applied for SSDI and am waiting on a response.
☐ No, I have not applied.

***Please note, that if you are not receiving any income from a job or looking for employment, it is recommended that you apply for SSI and/or SSDI.**

Insurance:

Do you currently have any insurance plan that pays for prescription drugs including Medicaid?
Yes ☐ No ☐

Do you have Medicare Benefits?
☐ No
☐ Yes If yes, please indicate what type of Medicare benefits you have below.
- ☐ **Part A** (Hospital Insurance)
- ☐ **Part B** (Medical Insurance)
- ☐ **Part D** (Prescription Drug Coverage) **Name of plan:** _____

If you are receiving Medicare, but do not have a Part D Plan for Prescription Drug Coverage, please explain why below:

_____

Patient Assistance Programs:

Many of the pharmaceutical companies, such as Johnson & Johnson or Pfizer will offer Patient Assistance Programs that help with the cost of the medication.

Have you applied for any Patient Assistance Programs through the pharmaceutical company?
Yes ☐ No ☐
If yes, which ones? _____

If no, why not? _____

Behavioral Health Provider:

Mental Health and/or Substance Use Provider: _____

Address: _____

Phone Number: _____

If Provider is a Community Mental Health Center, respond to questions below:

Which program is applicant involved in?

☐ Outpatient

☐ CARE

☐ IMPACT

☐ PATH (Homeless Outreach)

☐ SED/CYF

Case Manager Name: _____

Phone: _____ Email: _____

Participating Pharmacy where medications will be filled:

Pharmacy: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax (if known): _____

Participating health care center where Lab work will be done:

Lab Center: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax (if known): _____

Please complete the chart below for each medication you are requesting:

When are medications needed? (Next refill date): _____

List psychotropic and/or alcohol cessation/ substance use medication. **(If non-psychotropic and/or alcohol/substance cessation medication, it must be a medication used for side effects to this class of medications)**	**Dosage/ Strength**	**Frequency/ Quantity per month**	**Can generic be used? (Y/N)**	**Why is this medication prescribed? (DSM-5 Diagnosis is needed)**	**Co-pay amount, if applicable**

Lab Test Needed	Frequency	Why is this lab test ordered? (Please list current psychotropic medications that relate to labs being requested.)

Please make sure to acknowledge the following:

☐ I have reviewed a copy of the Department of Social Services' Notice of Privacy Practices and understand that I may ask questions about how my PHI will be used.

☐ 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 take all medications as prescribed by my healthcare provider.

☐ I agree to inform the South Dakota Department of Social Services (DSS), Division of Behavioral Health (DBH) if Medicaid, private health insurance, or patient assistance programs are obtained anytime within the approved application year. I understand that DSS-DBH will check on my eligibility with DSS-Medicaid and provide information to me and my provider regarding my eligibility for Medicaid.

☐ I hereby authorize the Department of Social Services, Division of 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 substance use disorder with any Mental Health Provider/Substance Use Disorder Provider, pharmacy, medical provider, provider of laboratory services, and/or pharmaceutical programs.

☐ I acknowledge that the Department of Social Services, Division of Behavioral Health will pay for my psychotropic medication, medication assistance for the treatment of substance use disorders, to include cessation and/or maintenance treatment, and /or related laboratory work on a time-limited basis, as determined by the Department of Social Services, Division of Behavioral Health

☐ I understand the above criteria and the terms/conditions of my participation in the program offered through the Department of Social Services, Division of Behavioral Health.

☐ I agree to the following as terms/conditions of this medication/laboratory funding agreement:

- I will take all psychotropic medication and medication for the assistance of treatment of substance use disorders, to include cessation and/or maintenance treatment 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 use 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, Division of Behavioral Health.
- I agree to inform the Department of Social Services, Division of 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.

_____ _____

Signature – Client/Patient Date

_____ _____

Signature – Legal Representative of Client/Patient (if applicable) Date

_____

Relationship to Client/Patient

Return to:

Division of Behavioral Health
3900 W. Technology Drive, Suite 1
Sioux Falls, SD 57106

Phone: (605) 367-5236
Fax: (605) 367-5239
Email: DSSBHINDMED@state.sd.us

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).