



February 13, 2023

Important Changes Coming Soon to Medicaid Eligibility

Due to the COVID-19 federal public health emergency, federal regulations did not allow Medicaid coverage to close even if individuals were not eligible. Effective April 1, 2023, federal law will again require Medicaid coverage to close if individuals are no longer eligible.

Over the next several months, DSS staff will be redetermining Medicaid eligibility. Prior to a redetermination, individuals with Medicaid coverage will receive a Medicaid review form. Once the review form is received, it must be completed immediately.

How can I help individuals with Medicaid coverage prepare?

They can directly call or email their local DSS office today to report any change in their contact information or circumstances.

They can also use the [DSS-EA-310 Change Report Form](#) to report changes in contact information or circumstances that could affect their eligibility. Only areas with a change need to be completed. All forms must be signed.

If you are sending this form in on their behalf, please fax or email immediately. See page 2 for a list of DSS office information.

What if someone is no longer eligible for Medicaid?

They will receive a notice in the mail if they're no longer eligible for Medicaid.

Individuals denied Medicaid may still be able to get health insurance and help to pay for it through the Health Insurance Marketplace. Plans are affordable and provide comprehensive coverage. For more information on the Health Insurance Marketplace, please call (800) 318-2596 (TTY: 1-855-889-4325) or visit www.healthcare.gov.

ABERDEEN

Fax: 605.626.2610
DSSRegion5EA@state.sd.us

BELLE FOURCE

Fax: 605.892.3616
RCCustomersupport@state.sd.us

BROOKINGS

Fax: 605.688.4339
DSSRegion6EA@state.sd.us

BURKE

Fax: 605.775.9121
DSSRegion4EA@state.sd.us

CANTON

Fax: 605.677.6808
DSSRegion7EA@state.sd.us

CHAMBERLAIN

Fax: 605.734.4505
DSSRegion4EA@state.sd.us

DEADWOOD

Fax: 605.578.1280
RCCustomersupport@state.sd.us

DUPREE

Fax: 605.964.1200
DSSRegion3EA@state.sd.us

EAGLE BUTTE

Fax: 605.964.1200
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ELK POINT

Fax: 605.356.3683
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FLANDREAU

Fax: 605.688.4339
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FORT THOMPSON

Fax: 605.734.4505
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HOT SPRINGS

Fax: 605.745.6562
DSSRegion2EA@state.sd.us

HURON

Fax: 605.353.7103
DSSRegion6EA@state.sd.us

KYLE

Fax: 605.867.1263
DSSRegion2EA@state.sd.us

LAKE ANDES

Fax: 605.487.7429
DSSRegion7EA@state.sd.us

LOWER BRULE

Fax: 605.734.4505
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MADISON

Fax: 605.256.5043
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MARTIN

Fax: 605.685.6652
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MCINTOSH

Fax: 605.273.4322
DSSRegion3EA@state.sd.us

MILBANK

Fax: 605.432.9563
DSSRegion5EA@state.sd.us

MISSION

Fax: 605.856.2031
DSSRegion4EA@state.sd.us

MITCHELL

Fax: 605.995.8929
DSSRegion6EA@state.sd.us

MOBRIDGE

Fax: 605.845.7126
DSSRegion3EA@state.sd.us

OLIVET

Fax: 605.387.2438
DSSRegion7EA@state.sd.us

PARKER

Fax: 605.297.3201
DSSRegion7EA@state.sd.us

PIERRE

Fax: 605.773.5390
DSSRegion3EA@state.sd.us

PINE RIDGE

Fax: 605.867.1263
DSSRegion2EA@state.sd.us

RAPID CITY

Fax: 605.394.1969
RCCustomersupport@state.sd.us

REDFIELD

Fax: 605.472.4298
DSSRegion6EA@state.sd.us

ROSEBUD

DSSRegion4EA@state.sd.us

SHIOUX FALLS

Fax: 605.367.5473
SiouxFallsEA@state.sd.us

SISSETON

Fax: 605.698.7842
DSSRegion5EA@state.sd.us

STURGIS

Fax: 605.347.3767
RCCustomersupport@state.sd.us

TIMBER LAKE

Fax: 605.964.1200
DSSRegion3EA@state.sd.us

TYNDALL

Fax: 605.589.4309
DSSRegion7EA@state.sd.us

VERMILLION

Fax: 605.677.6808
DSSRegion7EA@state.sd.us

WANBLEE

Fax: 605.685.6652
DSSRegion2EA@state.sd.us

WATERTOWN

Fax: 605.882.5045
DSSRegion5EA@state.sd.us

WHITE RIVER

Fax: 605.259.3202
DSSRegion4EA@state.sd.us

WINNER

Fax: 605.842.2574
DSSRegion4EA@state.sd.us

YANKTON

Fax: 605.668.3014
DSSRegion7EA@state.sd.us

Medical Assistance/TANF Change Report Form

Name: _____ Address: _____

City, State, Zip: _____ Phone: _____

Benefits Specialist: _____ Phone: _____

Changes must be reported to your Department of Social Services Benefits Specialist as soon as you become aware of them, but no later than 10 days from the date of the change. You can report changes by coming into your local Department of Social Services Office, calling your Benefits Specialist or you can use this form to report the changes.

CHECK THE SECTIONS THAT HAVE CHANGED

For Medical Assistance and/or Temporary Assistance for Needy Families (TANF) Programs:

Someone moved into your home (complete section below)

Name of Person			Indicate if Requesting Medicaid Assistance and/or Temporary Assistance for Needy Families (TANF)	
_____			Medical Assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
First	Middle Initial	Last	TANF?	<input type="checkbox"/> Yes <input type="checkbox"/> No

DOB	Gender	SSN	Does this person plan to file a federal income tax return next year? <input type="checkbox"/> Yes (answer questions A-C) <input type="checkbox"/> No	
A. Will this person file jointly with a spouse? If yes, name of spouse: _____				
B. Will this person claim any dependents on your tax return? If yes, list name(s) of dependents: _____				
C. Will this person be claimed as a dependent on someone's tax return? If yes, name of tax filer: _____ Relationship to tax filer: _____				

Someone moved out of your home (list person below):

Name of Person: _____	Date Left: _____
First MI Last	

Employment income changed. Check reason(s) below:

<input type="checkbox"/> Changed jobs	<input type="checkbox"/> Stopped working	<input type="checkbox"/> Started working fewer hours
Other. Describe change: _____		
Provide employer information below:		Average hours worked each WEEK: _____
Employer Name, Address and Phone Number		Wages/Tips (before taxes) \$ _____
		<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month
		<input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks
		<input type="checkbox"/> Yearly
If self-employed, describe type of work and the change in income below:		

Other income changed. Complete all that apply:

Source of Income	Amount	How often received?	Source of Income	Amount	How often received?
Unemployment			Alimony Received		
Pensions			Net Farming/Fishing		
Social Security			Net Rental/Royalty		
Retirement Accounts			Other Income Type		

Someone in the household is pregnant. If checked, complete questions below:

Name of person that is pregnant: _____ Due Date: _____ Number of babies: _____

Someone gave birth to a child. If checked, complete questions below:

Date of birth: _____ Name of newborn: _____ Gender: _____

For Medical Assistance Only:

Health insurance changed. Check reason below:

<input type="checkbox"/> Health insurance started	<input type="checkbox"/> Health insurance stopped	<input type="checkbox"/> Health insurance company changed
List the policy # _____		
Company Name/Address _____		

For Temporary Assistance for Needy Families (TANF) Only:

<input type="checkbox"/> Bank accounts/resources changed. Describe new accounts, increased amounts in existing accounts, etc. _____
<input type="checkbox"/> Bought, sold, traded, or gave away vehicles (cars, trucks, boats, etc.). Describe the change: _____
<input type="checkbox"/> The amount you pay for child support payments has started, stopped, or changed. Describe who the payment is for, who it is paid to, and the change in payment: _____
<input type="checkbox"/> School attendance changed. Provide name, change that occurred, and date of occurrence: _____

For ALL Programs: Would you like to Register to Vote?

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? Yes No

If you do not check either box, you will be considered to have decided NOT to register to vote at this time.

(Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.) If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

I understand that the information on this form is subject to verification by Federal, State, and local officials to determine that such information on this form is correct and complete. If any information is found to be incorrect, benefits may be reduced or terminated, and I may be responsible for paying the benefits back. I declare and affirm under penalties of perjury that this report form has been examined by me and to the best of my knowledge and belief is in all things true and correct. I understand I may be subject to criminal prosecution for knowingly providing incorrect information.	
_____	_____
Signature	Date