HARDSHIP CONSIDERATION (Calendar Year 2020)

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 extended family members or other household members? Please list whose care you are responsible for and provide documentation of expenses.

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☐ **YES** ☐ **NO** Do you have debt from prior substance use services, illness, or other out of pocket medical expenses? For gambling services only, identify gambling losses/debt. Please include bills or receipts of such debt and/or expenses.

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☐ **YES** ☐ **NO** Have you had any unforeseen/uncontrollable expenses (other than medical expenses)? Please give a detailed description of the expenses and provide bills/receipts.

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☐ **YES** ☐ **NO** Are there persons in your household who have disabilities or a substance use disorder? Please list each individual and what their specific disability is. Also, provide documentation of expenses that result from such disabilities or expenses that result from substance use services.

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☐ **YES** ☐ **NO** Do you or another household member have more than one disability? Please list the individual and the specific disabilities. Also, provide documentation of expenses that result from such disabilities.

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

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☐ **YES** ☐ **NO** Do you have excessive transportation costs? Please explain and provide documentation.

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☐ **YES** ☐ **NO** Do you have other expenses/circumstances that would make paying for mental health or substance use services an undue financial burden? Please explain and provide documentation.

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☐ **YES** ☐ **NO** Are you a person 18 years of age or older with a mental health and/or substance use disorder living with a parent or sibling because no other satisfactory living arrangement is available? If so, enter parent or sibling's income below so it may be deducted from the Means 101.

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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).