DSS-EA-243-12/02

State of South Dakota
Application for Chronic Renal Disease Program

NOTE: This is not an application for Medicaid, cash assistance or food stamps. If you want to apply for these programs, contact your local Social services office.

Instructions	Agency Use Only
1. Answer each question completely and accurately. Attach additional pages if necessary. 2. Include copies of all documents that are available to you including your Social Security card, Medicare card and last year's income tax return. **Do not send original documents.** 3. Sign and date the application. 4. Mail the application to your local Social Services Office. 5. An interview is not required.	Case Number: _____ Date Received: _____

A. Applicant's Name: _____ _____
Last First Middle Initial Social Security Number

Address: _____
Street City State Zip

Phone Number: _____ County: _____ Marital Status: _____

Date of Birth: ___ - ___ - _____ Sex: ☐ Male or ☐ Female U.S. Citizen: ☐ Yes or ☐ No

Race (can check more than one): ☐ White, ☐ American Indian, ☐ Black, ☐ Asian, ☐ Hawaiian.
Ethnicity: Also check here if Hispanic ☐.

B. If someone else is completing this form, please list the following information for the person completing the form:

Name: _____ Phone Number: _____

Address _____
Street City State Zip

Your title or relationship to applicant: _____

C. Members of Family Living at Home:

Name	Social Security Number	Relationship	Date of Birth
1.			
2.			
3.			
4.			

(List any additional family members on a separate sheet.)

D. Income and Earnings

List all types of earnings and income that you, your spouse or dependent(s) receive. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stub, benefit letter, etc.). If you filed an income tax return last year, please attach a copy of the return with the application. **Do not send original documents.** Examples of income include:

* Social Security
* Railroad Retirement
* Pensions/Retirement Benefits
* SSI
* Veterans' Benefits
* Rental Income
* Wages/Self-Employment
* Trust or Annuity Payments
* Oil Royalties/Mineral Rights

Who Receives Income? (name)	Type of Income	Employer or Source of Income	Amount	How Often Received?	Benefit ID Number (if applicable)

(List any additional income or earnings on a separate sheet.)

E. Resources

List all types of resources (assets) owned by you, your spouse or your dependent(s). Include verification such as copies of your most recent bank statement, burial agreement, etc. **Do not send original documents.** Examples of resources:

* Checking Account
* Savings Account
* Government Bonds
* Trust Funds
* Funeral Plans/Burial Arrangements
* Burial Plots
* Stocks and Bonds
* Certificate of Deposit
* Cash on Hand
* Safety Deposit Box
* Retirement Funds

Type of Resource	Owner	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

(List any additional resources on a separate sheet.)

Do you, your spouse or your dependent(s) own a car, truck, motorcycle, boat, trailer or other vehicle? ☐ Yes ☐ No. If yes, please complete the following information about your vehicle(s):

Owner(s)	Year	Make	Model	Value	Amount Owed

(List any additional vehicles on a separate sheet.)

Do you, your spouse or your dependent(s) own all or part of any real estate? ☐ Yes ☐ No
If yes, please complete the following for each piece of real estate.

Address	Owner	Value	Amount Owed

(List any additional property on a separate sheet.)

Do you, your spouse or your dependent(s) have a life insurance policy? ☐ Yes ☐ No
If yes, please complete the following information.

Policy Owner	Insurance Company Name and Address	Policy Number	Face Value	Cash Value

(List any additional life insurance policies on a separate sheet.)

F. Health Insurance

Do you have health insurance? ☐ Yes ☐ No. If yes, please complete the following information.

Health Insurance Company Name and Address	Type of Coverage (Hospital, Medigap, Rx)	Effective Date	Policy Number

(List any additional health insurance policies on a separate sheet.)

Do you have Medicare? ☐ Yes ☐ No. If yes, please complete the following information and attach copies (front and back) of your Medicare card.

Type of Coverage (check each box that applies)	Effective Date	Medicare ID Number
☐ Part A ☐ Part A		

G. Renal Disease Information

Physician name and address: _____

_____

Renal Disease Center and address: _____

_____

Do you receive dialysis? □ Yes □ No. If yes, list the date dialysis began: _____

Have you received a transplant? □ Yes □ No. If yes, list the transplant date: _____

Acknowledgement

I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my household income, resources, living arrangements or medical condition which might affect my right to receive assistance.

Authorization to Furnish Information and Release Information

I authorize any person, agency or institution to supply information to the Department of Social Services, concerning me, my spouse or dependent(s) and to allow inspection and copying of records about me, my spouse or dependent(s) by any representative of the Department. I authorize the Department to release information to providers, state or federal agencies in accordance with federal and state laws. This authorization is given only for use by the Department in administration of its programs. I understand that I may revoke this authorization at any time, except if records or information have already been disclosed. This authorization continues until I state in writing that it is no longer valid. I release any person, agency or institution from any legal responsibility to me, my spouse or my dependent(s) for supplying such information.

Signature of Applicant:	Date:
Signature of Representative and Title:	Date: