South Dakota Application for Medicare Savings Program

NOTE: This application **CAN** be used for a single person or couple (self and spouse)

1. Instructions:

Read this application carefully and follow all instructions given throughout the form. 1. Answer each question completely and accurately. Attach additional pages if needed. 2. If you need help completing or understanding this form, contact the Department of Social Services in the county where you live. 3. Include copies of all documents that are available to you. **Do not send original documents.** 4. Sign and date the application. 5. Mail the application to your local Social Services Office**.** 6. An interview is not required for these programs**.**	AGENCY USE ONLY Case Number _____ Date Received _____ Recipient ID(s) _____ _____

If you want more information on these programs, please check below.

☐ Supplemental Nutrition Assistance Program ☐ Low Income Energy Assistance

Are you interested in possible eligibility for the prior three months? ☐Yes ☐No
If yes, provide verification of income and resources (assets) for those months.

2. Personal Information:

Name (Last, First, Middle Initial)	Race(can check more than one) ☐White ☐American Indian ☐Black ☐Hawaiian ☐Asian	Ethnicity ☐Hispanic ☐None
Birthdate Sex Marital Status	If someone else is completing this form, provide the following information for the individual completing the form.	
Social Security Number U.S. Citizen ☐Yes ☐No	Name (Last, First, Middle Initial)	
Mailing Address	Mailing Address	
City State Zip	City State Zip	
Phone County	Phone	
Nursing Facility (if applicable)	Relationship to Individual	

3. Information on Spouse: Complete this information even if they are not requesting.

			*Completion is optional if NOT requesting assistance.		
Spouse's Name	Birthdate	Sex	Race*	U.S. Citizen*	Social Security Number*
				☐Yes ☐No	
Address of Spouse if Different from Applicant:					
Are you applying for Medicare Savings for your spouse, too? ☐Yes ☐No					

4. Information on Dependents Living with Applicant(s):

Name of Dependent	Birthdate	Relationship

5. Information on Medicare: Attach copies (front and back) of Medicare card(s).

Do you have Medicare? ☐Yes ☐No	Type of Coverage (Check Each Box that Applies) ☐Part A ☐Part B ☐Part D	Effective Date	Medicare ID Number
Part D Plan Name:			
Does your spouse have Medicare? ☐Yes ☐No	Type of Coverage (Check Each Box that Applies) ☐Part A ☐Part B ☐Part D	Effective Date	Medicare ID Number
Part D Plan Name:			

6. Information on Other Insurance: Attach copies (front and back) of insurance cards.

Have you or your spouse received, or are you eligible to receive services from Indian Health Services (IHS), Urban Indian Health, or other Tribal healthcare?
Self: ☐Yes ☐No Spouse: ☐Yes ☐No

Do you or your spouse have other health insurance? ☐Yes ☐No

	Health Insurance Company Name **and** Company Address	Type of Coverage (Hospital, Medigap, RX)	Effective Date	Policy Number
Self				
Spouse				

7. Income and Earnings: Attach verification of income.

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 stubs, benefit letter, etc.). Do not send original documents. Examples of income include:

* Social Security
* Railroad Retirement Benefits
* Pensions/ Retirement Benefits
* Civil Service Annuity
* Life Estate Income
* BIA General Assistance
* Payments on Contract for Deed
* SSI
* Veteran's Benefits
* Rental/Lease Income
* Insurance Payments
* Support Payments
* Contributions from Others
* IRA/KEOGH/401K Payments
* Wages/ Self-Employment
* Trust or Annuity Payments
* Oil/Mineral/Timber Rights

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	Date Paid

8. Property:

Do you or your spouse own all or part of any real estate? ☐Yes ☐No

If yes, please complete the following for each piece of real estate.

Address	Value	Amount Owed

Do you or your spouse own a car, truck, motorcycle, boat, trailer, camper or other vehicle? ☐Yes ☐No

If yes, please complete the following information about each vehicle:

Owner(s)	Year	Make	Model	Value	Amount Owed

9. Resources (assets): Attach verification.

List all types of the following resources (assets) owned by you or your spouse. Include any accounts or properties on which you or your spouse's name(s) appear. Include verification (such as copies of your most recent bank statement, trust funds, etc.).

Examples:

*Cash on Hand
*Safety Deposit Box
*Stocks/Bonds/Mutual Funds
*****Annuities
*****Checking Accounts
*Retirement Funds
*****Direct Express/Payroll Debit Cards
*Government Bonds
*****Burial Plots
*Savings Accounts
*****Trust Funds
*Certificates of Deposit
*****Life Estate
*****Funeral Plans
*****Burial Arrangements
*****Business Equipment
*****Property Rights

Attach additional pages if necessary.

If you and/or your spouse have no resources check here. ☐None

Type of Resource	Account Number	Value	Name of Bank, Financial Institution, Etc.

10. Life Insurance: Attach verification of cash value of policy.

Do you, or your spouse, have a life insurance policy? ☐Yes ☐No

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

Privacy Statement:
Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

Assignment of Rights of Payment for Medical Support and Other Medical Care:
(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party that may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

Applicant's Statement of Understanding and Agreement:
I understand that, by signing this application, I am agreeing to a review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and a review of any agency records. I also agree that my application authorizes these agencies to release to the Department of Social Services the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which the Department of Social Services may obtain the necessary proof.
I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

Applicant(s) or Representative Must Read and Sign:
State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. 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 the Department of Social Services of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse:	**Date:**

Notice of Nondiscrimination

As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Social Services directly or through a contractor or any other entity with which the Department of Social Services arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Social Services directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence Against Women.

The Department of Social Services provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written language in other formats (large print, audio, accessible electronic formats, other formats).

The Department of Social Services provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact your local DSS office.

If you believe that DSS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a discrimination complaint or grievance with: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. Phone: (605) 773-3305, Fax: (605) 773-7223, DSSInfo@state.sd.us. You can file a discrimination complaint or grievance in person or by mail, fax, or email. If you need help filing a discrimination complaint or grievance, the Discrimination Coordinator, Director of DSS Division of Legal Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, and 28 CFR Part 35, the Omnibus Crime Control and Safe Streets Act of 1968, Title IX of the Education Amendments of 1972, Equal Treatment for Faith-based Religions at 28 CFR Part 38, the Violence Against Women Reauthorization Act of 2013, and Section 1557 of the Affordable Care Act.

Language Assistance

1.Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

2.**Deutsch (German) -** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.Rufnummer: 1-800-305-9673 (TTY: 711).

3.**繁體中文(Chinese) -** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-305-9673（TTY：711）

4.ကညီ**(Karen) -** ့်သူ့်ဟ်သး-နမ့်ကတိၤ ကညီကျိာ်အယိ, နမၤန့်ၣ် ကျိာ်အတ်မၤစၢၤလ၊ တလၢာ်ဘူ့်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှ့်လီၤ. ကိး1-800-305-9673 (TTY: 711).

5.**Tiếng Việt (Vietnamese) -** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-305-9673(TTY: 711).

6.**नेपाली (Nepali) -** ध्यान दनुहोस:् तपाइलेनेपाल बोल्नहन्छ भन तपाइको ननम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनुहोसर ् 1-800-305-9673 (टटवाइ: 711

7.**Srpsko-hrvatski (Serbo-Croatian) -** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.Nazovite 1-800-305-9673 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

8.**አማርኛ (Amharic) -** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-305-9673 (መስማትለተሳናቸው: 711).

9.Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-305-9673 (TTY:711).

10.**Tagalog (Tagalog – Filipino) -** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-305-9673 (TTY: 711).

11.한국어 **(Korean) -** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-305-9673 (TTY: 711)번으로 전화해주십시오.

12.**Русский (Russian) -** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-305-9673 (телетайп: 711).

13.**Cushite Oroomiffa (Oromo) -** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa1-800-305-9673 (TTY: 711).

14.Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас.Телефонуйте. Телефонуйте 1-800-305-9643 (TTY: 711).

15.**Français (French) -** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-305-9673 (ATS : 711).