

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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <ol style="list-style-type: none"> 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 on the last page. 4. Mail the application to your local Social Services Office. 5. An interview is not required. | <p>Case Number: _____</p> <hr/> <p>Date Received: _____</p> <hr/> |

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 |
|-----------------------------------------------------------------|----------------|--------------------|
| <input type="checkbox"/> Part A <input type="checkbox"/> 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: _____

SIGNING UP TO VOTE – OPTIONAL

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 checked yes or did not check either box, the Department of Social Services will send you a voter registration form that you may complete at your convenience. Return the completed registration form to the County Auditor in your county of residence or to your local Department of Social Services office, Department of Human Services office, WIC office or military recruitment office. **The deadline for registration is 15 days before any election.**

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

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 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 application in private. If you believe that someone has interfered with your right 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

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: |