

State of South Dakota – Department of Social Services

Application for Medical Assistance for Workers with Disabilities

Fill in the circles like this  - 

Section A

Please use dark ink. Please print. If you need more room, add pages

What benefits are you applying for?	Applicant The person applying for benefits		Spouse	
		<input type="checkbox"/> Assisted Living	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> In Home Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Family Support Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Group Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Resource Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Other/Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Name				
Middle Name				
Last Name				
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Social Security Number				
Birth Date (MM, DD, YYYY)				
Marriage Status (mark one)	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Separated	<input type="checkbox"/> If divorced, list date:	
If deceased, date (mm, dd, yyyy)				
Current Address				
City				
State, ZIP				
Phone Number				
Mailing Address				
City				
State, ZIP				
County				

You and/or Your Spouse

Try to fill out as much of the form as you can.

We need facts about you and your spouse. We need to know about your spouse even if your spouse does not want benefits.

If you are not married, do not fill in the sections marked spouse.

Section A

You and/or Your Spouse

(continued)

	Applicant		Spouse	
E-mail				
Live in South Dakota?	Yes	No		
Plan to stay in South Dakota?	Yes	No		
Hispanic or Latino? (optional)	Yes	No		
Race (optional)	Native American or Alaska Native Asian Black or African American Hawaiian or Pacific Islander White			
If Native American, Have you received or are you eligible for a service from Indian Health Services (IHS), Urban Indian Health or other tribal healthcare?	Yes	No		

Section B

Citizenship

Provide citizenship documentation if not a US citizen.

	Applicant		Spouse	
Are you a U.S. Citizen? If yes, go to Section C	Yes	No		
	If no, give facts below			
Are you a refugee or legally admitted immigrant?	Yes	No		
Date you entered the U.S. mm/dd/yyyy:				
Are you registered with the U.S. Citizenship and Immigration Services?	Yes	No		
	_____ If yes, document type			
	_____ Alien, I-94, or passport number			

Section C

People Helping You

Person helping with legal matters - Please provide a copy of documentation.

Do you have someone helping with legal or financial matters? Yes No

If yes, tell us about that person: Guardian Power of Attorney

_____ Name

_____ Address

City State Zip Code

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone E-mail

Person helping you fill out this form

Is someone helping you or your spouse fill out this form? Yes No

_____ Name

_____ Relationship or Organization

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone E-mail

Person who can be contacted for information

If you want, you can give someone the right to act for you. That person can:

- Give and get facts for this application
- Take any action needed for the application process

Take any action needed for you to get benefits. This includes reporting changes.

_____ Name Relationship to you

_____ Address

City State Zip Code

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone E-mail

If you would like DSS to release forms or official notices to this individual or anyone else, please complete the authorization on page 18.

Section D

**Your Home
or Where
You Live**

Where do you live?

Applicant

- Nursing home
- Assisted living center
- Group home for people with intellectual or developmental disabilities (ICF/IID)
- Your own home
- With someone else in their home
- House paid for by someone else
- Other

Do you have any unpaid medical bills from the last 3 months? Yes No
If yes, please provide a copy of the bills.

What month are you requesting assistance from Medicaid to start?

Month

Name of your primary care physician and location

Section E

**Resources/
Assets
(continued)**

Reminder:
Answer the
questions for
you and/or
your spouse.

**If you need
more room,
copy the
pages.**

Employee payroll debit card or Direct Express Federal Benefits cards owned by you?				<input type="radio"/> Yes	<input type="radio"/> No
Account 1	_____		_____		
	Account Number		Names on account		
	_____			_____	
Bank or company name			Value		
_____			_____		
City		State	Zip	Phone	
Certificates of deposit (CD's), savings bonds or money market accounts owned by you?					
				<input type="radio"/> Yes	<input type="radio"/> No
Account 1	_____		_____		
	Account Number		Names on account		
	_____			_____	
Bank or company name			Value		
_____			_____		
City		State	Zip	Phone	
Account 2	_____		_____		
	Account Number		Names on account		
	_____			_____	
Bank or company name			Value		
_____			_____		
City		State	Zip	Phone	
Health savings accounts established through a bank, credit union, insurance company or employer owned by you?					
				<input type="radio"/> Yes	<input type="radio"/> No
Account 1	_____		_____		
	Account Number		Names on account		
	_____			_____	
Bank or company name			Value		
_____			_____		
City		State	Zip	Phone	

Section E

Resources/ Assets (continued)

Reminder:

Answer the questions for you and/or your spouse.

Please read annuity disclosure information and information concerning when the state shall be named beneficiary of an annuity provided on page 19.

Stocks or mutual funds owned by you? <input type="radio"/> Yes <input type="radio"/> No			
Account 1	_____		_____
	Account Number		Names on account
	_____		_____
Bank or company name		Value	
_____		_____	
City	State	Zip	Phone
Account 2	_____		_____
	Account Number		Names on account
	_____		_____
Bank or company name		Value	
_____		_____	
City	State	Zip	Phone
Retirement, pension funds, Keogh, 401Ks or IRAs owned by you? <input type="radio"/> Yes <input type="radio"/> No			
Account 1	_____		_____
	Account Number		Names on account
	_____		_____
Bank or company name		Value	
_____		_____	
City	State	Zip	Phone
Account 2	_____		_____
	Account Number		Names on account
	_____		_____
Bank or company name		Value	
_____		_____	
City	State	Zip	Phone
Annuity owned by you? <input type="radio"/> Yes <input type="radio"/> No			
Account 1	_____		_____
	Account Number		Names on account
	_____		_____
Bank or company name		Value	
_____		_____	
City	State	Zip	Phone

Section E

Resources/ Assets (continued)

Reminder:

Answer the questions for you and/or your spouse.

Any other account owned by you or your spouse? <input type="radio"/> Yes <input type="radio"/> No			
Account 1	_____		_____
	Account Number		Names on account
	_____		_____
	Bank or company name		Value
	_____		_____
	City	State	Zip
			Phone

Cash on hand? <input type="radio"/> Yes <input type="radio"/> No	If yes, how much cash: _____
---	------------------------------

Life Insurance owned by you or your spouse? <input type="radio"/> Yes <input type="radio"/> No			
_____		_____	
Name of insured person (first, middle, last)		Name of policy owner	
_____	_____		
Policy Number	Insurance Company		

Company Address		City	State
			Zip Code
Phone: _____			
_____	_____	<input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Yearly	
How much is the premium?	Who pays the premium?	How often is the premium paid?	

_____		_____	
Name of insured person (first, middle, last)		Name of policy owner	
_____	_____		
Policy Number	Insurance Company		

Company Address		City	State
			Zip Code
Phone: _____			
_____	_____	<input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Yearly	
How much is the premium?	Who pays the premium?	How often is the premium paid?	

Section E

Resources/ Assets (continued)

Do you or your spouse have any financial arrangements such as contracts, insurance, or accounts designated for burial? <input type="radio"/> Yes <input type="radio"/> No If yes, list below and provide a copy.		
_____	_____	_____
Where? (Applicant)	Date purchased (mm/dd/yy)	Value
_____	_____	_____
Where? (Spouse)	Date purchased (mm/dd/yy)	Value
Are you or your spouse named in any trusts or have ownership in any trusts? If yes, give facts below and provide a copy of the trust. <input type="radio"/> Yes <input type="radio"/> No		
_____	_____	
Owner/name of trust	Values	

Reminder:

Provide copies of Liens and registrations.

Do you or your spouse have any cars, trucks, boats, or other recreational vehicles? <input type="radio"/> Yes <input type="radio"/> No		
_____	_____	_____
Make/Model	Year	value
_____	_____	_____
Owner	Amount owed	Primary use
_____	_____	_____
Make/Model	Year	Value
_____	_____	_____
Owner	Amount owed	Primary use
Do you or your spouse own a home (includes mobile)? <input type="radio"/> Yes <input type="radio"/> No		
_____	_____	_____
Address of the home	Amount owed	Value
If you are not living in your home right now, do you plan on returning to your home? <input type="radio"/> Yes <input type="radio"/> No		
Please provide a copy of the latest real estate tax statement.		
Do you have a reverse mortgage on your home? <input type="radio"/> Yes <input type="radio"/> No		
Did you receive lump sum? <input type="radio"/> Yes <input type="radio"/> No	If yes, how much? _____	
Do you receive a monthly payment? <input type="radio"/> Yes <input type="radio"/> No	If yes, how much? _____	

Section E

Things You are Paying for or Own

Do you or your spouse own or share ownership of any other land, lots, or real estate? If yes, list property address/county below. <input type="radio"/> Yes <input type="radio"/> No	
_____	_____
Address or location	Value
_____	_____
Address or location	Value

Do you or your spouse have a life estate or remainder interest in property? If yes, list property address/county below. <input type="radio"/> Yes <input type="radio"/> No		
_____	_____	_____
Address or location	Amount of land	Value
_____	_____	_____
Address or location	Amount of land	Value

Provide a copy of contract.

Do you or your spouse have any promissory notes, mortgage notes or a contract for deed? If yes, provide a copy of the contract. <input type="radio"/> Yes <input type="radio"/> No	
The terms are: <input type="radio"/> Negotiable <input type="radio"/> Non-negotiable Value: _____	

Do you or your spouse have mineral, oil, gas, timber, wind, or surface rights? If yes, please complete below: <input type="radio"/> Yes <input type="radio"/> No			
_____	_____	_____	_____
Owner	Address or location	Type	Value
_____	_____	_____	_____
Owner	Address or location	Type	Value

Do you or your spouse own any business equipment, machinery, livestock, antiques, collections other than household furnishings? <input type="radio"/> Yes <input type="radio"/> No	
_____	_____
Item	Value
_____	_____
Item	Value
_____	_____
Item	Value

Do you or your spouse hold any interest in a partnership or corporation? If yes, list below: <input type="radio"/> Yes <input type="radio"/> No	

Name of partnership/corporation	

Section F

Tell Us About Your Household

Housing costs Do you have shelter costs? Yes No
If yes, tell us the costs you have for the home you live in. All shelter costs must be verified.
Please attach proof of cost (mortgage/rent payment and tax, utility and insurance bills).

	Other – List Name _____
Rent or house payment	
Tax on home	
Utilities	
Home insurance	

Section G

Medical Facts

Medicare

Do you have Medicare? If yes, please complete below:

Yes No

	Applicant	Spouse
If yes, mark the type	<input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D	<input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D
Part D Plan Name		
Start date : (mm/dd/yy)		
Claim number (HICN)		
Medicare premium (monthly cost)?		

LTC Insurance

Do you have long term care insurance?

Yes No

Is this a Partnership Plan?

Yes No Unsure

Name of insured person (first, middle, last)		Name of policy holder	
Policy Number	Insurance Company		
Company Address		City	State
		Zip Code	
Phone:			
How much is the premium?	Who pays the premium?	<input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Yearly How often is the premium paid?	

Reminder:
Provide a copy
of cards.

Health Insurance: Do you have private health insurance or Medicare supplemental insurance? Yes No

Name of insured person (first, middle, last)		Name of policy holder	
Insurance company	Insurance company address		
Policy number	Coverage start date	Coverage end date	Type of coverage
How much is the premium?	Who pays the premium?	<input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Yearly How often is the premium paid?	
Do you get this insurance through a job you had or have? <input type="radio"/> Yes <input type="radio"/> No		If yes, list employer's name	

Section H

Money Coming into Your Home

(income)

**Save Time:
Veterans &
veteran's
widows must
apply for
benefits.
Contact your
local VA office.**

**Medicaid
applicants must
apply for all
benefits they
may be entitled
to receive.**

Income
Applicant
Do you get Social Security?
<input type="radio"/> Yes <input type="radio"/> No

If yes, what is the monthly amount?
Do you get Supplemental Security Income?
<input type="radio"/> Yes <input type="radio"/> No

If yes, what is the monthly amount?
Are you a veteran?
<input type="radio"/> Yes <input type="radio"/> No
Do you get veteran's benefits?
<input type="radio"/> Yes <input type="radio"/> No

If yes, what is the monthly amount?

Claim number
Do you get railroad retirement benefits?
<input type="radio"/> Yes <input type="radio"/> No

If yes, what is the monthly amount?

Claim number
Do you get civil service retirement payments?
<input type="radio"/> Yes <input type="radio"/> No

If yes, what is the monthly amount?

Claim number
Do you get any other retirement or pension payments?
<input type="radio"/> Yes <input type="radio"/> No

If yes, what is the monthly amount?

Source

What is the claim number?

Section I

Money
Coming into
Your Home

Applicant

Do you get any payments from annuities?

Yes No

If yes, what is the monthly amount?

Company

What is the claim number?

Do you get dividends from stock, bonds or insurance?

Yes No

If yes, what is the amount?

How often?

Source

Do you get rental income?

Yes No

If yes, what is the amount?

How often?

Do you expect to get money from:

- a lawsuit – a personal injury settlement – an accident liability claim – an inheritance?

Yes No

If yes, please list the name and phone number of a person who can tell us about the settlement.

Do you get money from leases or royalties from oil, gas, mineral, wind, timber or surface rights?

Yes No

If yes, what is the amount?

How often?

Are you self-employed?

Yes No

Gross income amount

If self-employed,
please provide
your most
current income
tax forms.

Section I

Money Coming into Your Home

(continued)

Applicant	
Do you get money from a job?	
<input type="radio"/> Yes <input type="radio"/> No	
_____ If yes, what is the amount before taxes?	
_____ How often?	
_____ Name of Employer	
Do you get the following types of money from anyone else or anywhere else? • cash • gifts • payments you get for loaning money to someone else • bills paid for you • child support • training • alimony • income from Life Estate • other	
<input type="radio"/> Yes <input type="radio"/> No	
_____ If yes, what type of money do you get?	
_____ If yes, who do you get the money from and why?	
_____ If yes, what is the amount you get?	

Section J

Programs You've Applied For

Money you or your spouse might get from other programs Are you waiting for an answer on an application for one of the programs listed below? Mark any that apply	
Applicant	
<input type="radio"/>	Social Security
<input type="radio"/>	Supplemental Security Income (SSI)
<input type="radio"/>	Veteran's benefits
<input type="radio"/>	Other benefits _____

Section K

Authorization to Release Information is optional. This is used when you want us to communicate with others about your application or case.

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

EA Authorization to Release Information

I, _____, authorize the Department of Social Services (DSS), Division of Economic Assistance (EA) to disclose my personal information to the following individual/facility: _____
Address: _____

Phone Number: _____ Fax Number: _____

This authorization is for the time period from: _____ to _____
(time period not to exceed one year)

This form does not authorize disclosure of information beyond the limits of this authorization. Information that the Department has obtained from a source other than the applicant or recipient is not subject to disclosure.

I allow DSS-EA to release only the following checked information to the above stated party: (check all that apply)

- Copy of Application/Renewal Form Dated: Month(s)____ Year(s)_____ Address on File
 Copy of Notices from DSS-EA Relating to Application/Renewal Form Dated: Month(s)____ Year(s)_____

It is my intention that my personal information which has been provided to the above named individual/facility not be re-disclosed by said individual/facility without further written authorization from me.

I understand that I may revoke this authorization by sending a written notice to the Department of Social Services, Division of Economic Assistance, 700 Governors Drive, Pierre, SD 57501.

I understand that I may refuse to sign this form and that I do not have to sign this form in order to apply for or renew eligibility for benefits from the Division of Economic Assistance.

Signature: _____

Printed Name: _____ Date: _____

Address of Individual Signing: _____ City/State/ZIP: _____

- If signed by someone other than Applicant/Recipient indicate relationship (check appropriate box)
 Spouse Parent (if for child under 18) Power of Attorney Legal Guardian

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. **unD (Karen)** - ၵ်သုၵ်းသး-နမ့ၵ်တိၵ် ကညိၵ်အိၵ်အိၵ်, နမ့ၵ် ကျိၵ်အိၵ်အိၵ်အိၵ် တလၵ်သုၵ်းသးနိတံၵ်သုၵ်းနိလိၵ်. ကိး:1-800-305-9673 (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 ढदनुहोस् तपाइले नेपाल ढोल्नहन्छ भन तपाइको ढनिम्त भाषा सहायता सवाहरू ढनःशल्क रूपमा उपलब्ध छ । फोन गनुहोस् 1-800-305-9673 (ढटढटवाइः 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)** - ማሰታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዙዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-305-9673 (መስማት ለተሳናቸው: 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 nang walang 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 전화해 주십시오.
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. Bilbilaa 1-800-305-9673 (TTY: 711).
14. **Український (Ukrainian)** - УВАГА: Якщо ви говорите 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).

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
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - 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.

Section L

Statement of Understanding

Assignment of Medical Support, Insurance Proceeds

As application for and acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation of any rights to medical support, insurance proceeds, or both that the applicant or recipient may have. Any rights or amounts so assigned or subrogated shall be applied against the cost of the applicant's or recipient's care.

Disclosure of Annuities and State to be named as Remainder Beneficiary

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6012 requires individuals applying for long-term care medical assistance and an individual whose eligibility is being reviewed for purposes of determining whether the individual continues to be eligible for long-term care assistance to disclose the description of any interest the individual or the individual's spouse has in an annuity or similar financial instrument. Failure to disclose this information results in ineligibility for assistance. In addition, a recipient of long term care assistance must name the department as a preferred remained beneficiary of any interest the individual or individual's spouse has in an annuity or similar financial instrument purchased and owned after February 7, 2006.

Note: The annuity will also be considered a resource.

Privacy Act Statement

Federal and State Law and Regulations limit the use and disclosure of confidential information concerning applicants and recipients of economic and medical assistance programs to purposes directly related to the administration of those programs. When you apply for assistance, you will be asked to provide your Social Security Number (SSN) on the application form. Title 42 of the Code of Federal Regulations Part 435.910(a), requires the furnishing of a SSN as a condition of eligibility for Medicaid. The Department uses your number in its computer processing of eligibility determination, welfare fraud investigation and audits. SSNs are also used to verify income information through agencies such as the IRS, Department of Labor, and Social Security Administration, etc., to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in benefits easier to implement and to determine the accuracy and reliability of information given to the department by applicant for and recipients of assistance.

Civil Rights Guarantee

The provisions of the Civil Rights Act of 1964, as amended, also apply to your case and department representatives shall not, on the grounds of race, color, creed, religion, sex, disability, ancestry, or national origin, exclude you from participation in, deny the benefits of, or otherwise subject you to discrimination under any program or activity administered by the department. Any person who feels that their civil rights have been violated may request a fair hearing. You may also file a complaint by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or by calling (605) 773-3305

Verifications

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials will verify information given on this form to determine if it is correct. A department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your Medical case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

Medicaid Estate Recovery Program

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased medical assistance recipients who were permanently institutionalized or who were at least 55 years of age and for whom the Department made a payment for nursing facility services, intermediate care facility services for individuals with intellectual disabilities, other medical institutional services, home and community based services, hospital services, and prescription drug services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be liable for recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended on behalf of the recipient. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by a recipient who has received a benefit from the Department of Social Services for the services of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach. Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the nursing home or other facility if the resident was receiving medical assistance from the Department at the time of death. Information in regards to the Estate Recovery Program, can be located at <http://dss.sd.gov/keyresources/benefitfraud/estate.aspx>.

Did you...

1. Include the “Items we requested” listed throughout the application.
2. Sign and date below.

By signing below, I agree:

- I understand that any false statements which I may make and any failure on my part to report any change in circumstance which would affect my eligibility for payment from programs administered by the South Dakota Department of Social Services constitutes a crime and that I could be prosecuted under South Dakota criminal laws.
- I agree to provide information upon request from the Department of Social Services concerning any asset or estate which may be subject to recover, estate recover, or medical assistance liens by the State of South Dakota.

Applicant should sign the application unless incapacitated or represented by a legal (court appointed) guardian. A representative, who can make health related decisions, may sign the application on behalf of the incapacitated or deceased applicant. The applicant’s mark should be witnessed by a person familiar with the applicant.

Authorization to Furnish and Release Information

I hereby authorize any person, agency, or institutions to supply information requested by the Department of Social Services concerning me or my family, and allow inspection and reproduction of the records in his or their possession pertaining to me or my family by any duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

This authorization is given only in connection with its use by the Department in the administration of its programs and for no other purpose. It shall continue in effect until such time as I state in writing that it is no longer valid.

I therewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

Applicant		Spouse	
Sign above	Date	Sign above	Date
_____	_____	_____	_____
Print name		Print name	
If you are a parent, guardian, authorized representative, court appointed administrator, executor, or have power of attorney for this person, sign below:			

Sign here (must provide proof)			Date
Sign here if you are a witness (only needed if anyone above signed with an “X” or other mark)			Date
Printed name of witness			