Request for Long-Term Care or Home Community Based Services Waiver Assistance

For individuals already Medicaid eligible; if not Medicaid eligible a full application needs to be completed.

Recipient Name:	**Social Security Number:**	**Date of Birth:**
Current Address: **City:** **State:** **Zip:**		**Phone Number:**
Spouse: ☐ No ☐ Yes **If yes, please list name:**		
What are you requesting? ☐ Nursing Facility Care ☐ Assisted Living ☐ Hospitalization ☐ CHOICES Waiver ☐ In-Home Waiver ☐ Family Support Waiver ☐ Other/Unknown **Date services requested to begin:**		
Name of Hospital or Facility:		**Phone Number:**
Admit Date:	**Discharge Date: (if known):**	
If you are currently in the hospital, what is your discharge plan? ☐ Unknown at this Time ☐ Discharge to Nursing Facility ☐ Discharge to an Assisted Living Facility ☐ Discharge to Home **If discharging to a facility, please complete** Facility Name: Phone Number: Admit Date (if known): Discharge Date: (if known):		
Physician Name:	**Physician Address:**	
If applying for CHOICES waiver who is your: **Case Management Provider:** **Case Manager:**		
1) If you are single, will the lowest balances of all your asset(s)/resources such as savings and checking accounts, accounts at the facility, stocks/bonds, certificates of deposits, annuities, retirement accounts, etc., stay below $2000 this month? ☐ Yes ☐ No If you are married, a Resource Assessment may be required and we may contact you to gather additional information.		
2) Have you transferred, sold, or given away any assets in the past 60 months such as money, land, vehicles, etc. ☐ No ☐ Yes If yes, please list:		
3) Do you or your spouse have funds in an annuity or any similar financial instrument? ☐ Yes ☐ No If this was purchased after February 7, 2006, the State of South Dakota must be named as a preferred remainder beneficiary.		
Individuals Assisting You:		
Do you have a Power of Attorney, Guardian or Conservator? ☐ No ☐ Yes If yes, please provide a copy of the documentation and list the contact information below:		
Name: Phone:	Address: City: State: Zip:	
This form submitted by:	Phone #:	

Please have the recipient sign the authorization to furnish and release information on the back of this form. If the recipient is unable to sign the authorization, please send a copy of the Financial Power of Attorney or guardianship document.

AUTHORIZATION TO FURNISH AND RELEASE INFORMATION

I hereby authorize any person, agency or institution to supply information requested by the Department of Social Services concerning me or my family, and to allow inspection and reproduction of 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 herewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

CIVIL RIGHTS GUARANTEE

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. You may file a complaint by contacting: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. (605)773-3305. In accordance with state and federal laws, you may also file a complaint with the following agencies: (1) the South Dakota Division of Human Rights (605)773-3681 and the (2) Office of Civil Rights, Jocelyn Samuels, Director, US Department of Health and Human Services, 200 Independence Ave, S.W. Room 509F HHH Bldg, Washington DC 20201.

ACKNOWLEDGEMENT

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 recovery, estate recovery, or medical assistance liens by the State of South Dakota.

SIGNATURES

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.

Signature of Applicant or Recipient	Date	Signature of Spouse	Date
Witness to Applicant's mark	Date	Signature of Legal Guardian or Power of Attorney	Date