DSS-EA-249 01/08

FOR AGENCY USE ONLY
RECEIPT DATE _____
CASE NUMBER

DISABLED CHILDREN PROGRAM APPLICATION OR ELIGIBILITY REVIEW

″ INSTRUCTIONS FOR COMPLETING THE APPLICATION

Please read all questions carefully and answer completely. If you need more space, use a separate sheet. This information will be used to make disability and "level of care" determinations, and to estimate the cost of home care medical services for your child. We will send requests to your child's medical providers for medical records. Information that you provide, such as the applicant child's age, Social Security Number, earned or unearned income and resources will be verified to determine program eligibility.

Please return the application to the following address: Office of Medical Eligibility, Department of Social Services, 700 Governors Drive, Pierre, SD 57501-2291. If you need help completing or understanding the form, contact the Office of Medical Eligibility @ 605-773-4678.

″ APPLICATION

Child's Name _____

Child's Social Security Number _____ Date of Birth_____

Completion of Race, Social Security Number (SSN), and Citizenship is optional for persons NOT requesting assistance

Child's Sex:	Child's Race (can check more than one):		
♦ Male	♦ White	♦ Black	♦ American Indian
♦ Female	♦ Asian	♦ Hawaiian	♦ Ethnicity (Also check here if Hispanic)

1. Have you applied for Supplemental Security Income (SSI) for your child listed above? Yes ♦ No ♦

* If yes, please attach please attach a copy of the SSI notice/letter along with this application. *

Parent's Name _____

Address _____ City_____ State_____ Zip_____

County _____Telephone Number: _____ _____ Work _____

List Non-Custodial Parent if applicable:

Parent's Name _____

Address _____ City_____ State_____ Zip_____

County _____Telephone Number: _____ _____ Work _____

Do you have other dependent children in the home? Yes ♦ No ♦

If yes, are they on South Dakota Medicaid? Yes ♦ No ♦

A. General Information

1. Does your child have medical bills in the last 3 months? Yes ♦ No ♦

2. Does your child attend school? Yes ♦ No ♦ If yes, name of School and Address _____

_____

♦ Regular class placement grade _____ ♦ Special Education ♦ Boarding Student

B. Physicians

1. List the name, address and telephone number of your child's primary physician.

Name _____ Specialty _____
Specialty _____

Address _____

Telephone (____) _____ - _____ Frequently Seen _____

2. List other physicians who care for your child.

Name/Address	Specialty	Telephone	Frequently Seen
_____	_____	(____) _____ _____	_____
_____	_____	(____) _____ _____	_____
_____	_____	(____) _____ _____	_____
_____	_____	(____) _____ _____	_____
_____	_____	(____) _____ _____	_____
_____	_____	(____) _____ _____	_____
_____	_____	(____) _____ _____	_____

C. Institutional Care

Has your child been hospitalized in the last 12 months? Yes ♦ No ♦ If yes, list where, and reason.

_____

_____

_____

_____

_____

_____

D. **Activities of Daily Living**

1. Mobility: Please note which apply to your child.

	Independent ⎫	Needs Assistance ⎫	Unable ⎫	Explain Assistance needed (# persons, supervision, device)
Walk				
Crawl				
Sit Up				
Transferring				
Positioning (Bed or Chair)				

2. Sight, Hearing: Please note which apply to your child.

	Normal ⎫	Explain Impairment		Legally	
		Correctable	Non-Correctable	Blind ⎫	Deaf ⎫
Sight					
Hearing					

3. Communication: Please note which apply to your child.

Good ⎫	Fair ⎫	Poor ⎫	None ⎫	Explain Communication (Gestures, sign language, device)

4. General Hygiene: Please note which apply to your child.

	Independent ⎫	Needs Asst. ⎫	Unable ⎫	Explain Assistance (#person, device, special precautions)
Bathing				
Dressing				
Grooming				

5. Nutrition:

a. Please note which apply to your child.

	Independent ⎫	Needs Asst. ⎫	Unable ⎫	Explain Assistance (#person, device, special precautions)
Eating				

b. Please indicate below how your child is able to feed, how often and for how long.

	Feedings Per Day	Length Of Feeding	Explain Special Diet or Formula	Indepen-dent ⎫	Needs Asst. ⎫	Unable ⎫
Oral						
Gastrostomy						
Nasogastric						
Parenteral (intravenous)						

6. Toileting: Please note which apply to your child.

	Independent ⎫	Needs Asst. ⎫	Unable ⎫	Explain Assistance (#person, device, special precautions)
Bladder				
Bowel Control				

7. Level of Functioning/Interactions: Please note which apply to your child.

	Good ⎫	Fair ⎫	Poor ⎫	None ⎫
Family				
Friends				
School				
Recreation				
Community				

8. Behavior:

Does your child have any behavior problems (i.e. uncooperative, injurious to self/others)? Yes ♦ No ♦

If yes, please explain. _____

_____

_____

E. **Medical Condition**

1. What is your child's primary medical diagnosis? _____

   What is your child's prognosis? _____

2. If this is a new application briefly describe in your own words your child's major condition(s), when (month/year) it first became evident include any other medical conditions (i.e. respiratory, cardiovascular, neurological). If this is an eligibility review, please describe any new medical conditions. _____

   _____

   _____

   _____

   _____

   _____

3. Is your child's developmental (functional) level age appropriate? Yes ♦ No ♦

   If no, what is the developmental age? _____

If your child is developmentally disabled and a current psychological report is available, send this report with your application.

Please list the psychologist who did the testing _____

4. Respiratory:

Does your child require any of the following respiratory aids?

1. Suction (specify bulb or machine) _____

   Frequency _____

2. Oxygen_____ Humidification _____

   Number of hours per day_____ Liter flow_____

3. Chest Therapy_____ Times per day _____

4. Respirator/ventilator_____ Continuous_____

5. Other _____

5. Skin:

   Does your child have a history of evidence of skin breakdown such as open wounds or bedsores?

   Yes ♦ No ♦

   If yes, explain special precautions and treatment required. _____

   _____

6. Seizures:

   Does your child have a history or evidence of seizures? Yes ♦ No ♦

   If yes, explain the history, frequency, type and level of control of seizure._____

   _____

   _____

7. Physical Measurements:

   What is your child's Height _____ Weight _____

8. Other Conditions:

   Briefly describe any other medical conditions._____

   _____

   _____

   _____

   _____

F. Nursing Care

1. Does your child receive nursing care at home or school? Yes ♦ No ♦

   If yes, note the hours and type below.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Registered Nurse							
Lic. Practical Nurse							
Home Health Aide							

2. List the agency and/or individual providing nursing care:

Name/Agency	Location (i.e. home, school)

3. Briefly describe the nursing treatment or procedures:_____

_____

_____

_____

_____

_____

G. Therapies

Does your child receive therapeutic services? Yes ♦ No ♦ If yes, note the hours and type below

Type of Therapy	# Visits Per Week	# Visits Per Week	# Visits Per Week	Agency or individual Providing Therapy
Physical				
Occupational				
Speech				

H. Medications

List all medications your child takes below.

Medication Name	Dose	Frequency	Explain Special Precautions

I. **Equipment/Supplies**

List all equipment including orthodic and prosthetic devices (i.e. ankle, foot orthosis, braces & artificial limbs) and supplies used for your child (i.e. suction machine, oxygen, feeding pump & pole).

Item	How Often Used	Frequency of Replacement

J. **Physician Plan of Care**

In relation to your child's disability, outline what your physician has trained you and/or instructed you to observe and monitor your child for:

_____

_____

_____

What actions are you instructed to take? _____

_____

_____

_____

K. **Costs**

Federal Regulations require that the cost of care in the home cannot exceed the cost of care in Medical Facility.

a. If this is a new application, estimate and list the monthly costs for each service used in your child's care and who pays the cost. Do not include costs of equipment, orthotics or prosthetics that have already been purchased. If your child is already eligible for the Disabled Children Program and this is a review of continued eligibility, you do not need to complete question K.a.

		Cost Paid By:			
Services	Service Cost/Month	School ⎫	Parent ⎫	Insurance ⎫	Other ⎫
Nursing Care					
Physical Therapy					
Occupational Therapy					

(cont.) Services	Service Cost/Month	School ⎫	Parent ⎫	Insurance ⎫	Other ⎫
Speech Therapy					
Respiratory Therapy					
Physicians					
Medications					
Equipment					
Supplies					
Special Formula					
Other					

b. List the estimated costs during the next year for anticipated hospitalizations or surgical procedures and for replacement or purchase of equipment (list the type), orthodics or prosthetics.

_____

_____

_____

_____

_____

_____

L. Income

Does your child have income? Yes ♦ No ♦

List all income and benefits that your child receives from any source. Example are: Supplemental Security Income, Social Security, dividends, insurance payments or annuities, interest income on bonds, CD's or savings accounts, child support, tribal lease income, fund raisers, contributions and any other income. **Please attach proof of income.**

Type of Income	Amount	How Often Received

M. Resources

1. Does your child have cash on hand and/or savings at home including money held for your child's use by someone else? Yes ♦ No ♦ If yes, list the amount _____

2. Does your child have savings, checking, money market funds, certificates of deposit, trust funds, stocks and bonds, U.S. Government Savings Bonds, individual monies (IIM) or other? Yes ♦ No ♦

   (Include all resources your child is co-owner of including those purchased by someone else.)

   If yes, list below:

Type of Resource	Bank Name or Asset Location and Address	Account Number	Amount or Value

3. Does your child have an ownership interest, either alone or in joint ownership, of property or other assets such as land, buildings, vehicles, farm equipment, livestock, or any other item of value? Yes ♦ No ♦
   If yes, list below:

Type of Property	Description or Location	Amount Owned	Value

4. Does your child own life insurance polices? Yes ♦ No ♦ If yes, list below:

Name of Company	Address	Policy Number	Cash Value	Face Value

5. Does your child have a prepaid burial fund? Yes ♦ No ♦ If yes, where _____

   Account amount _____ Is interest paid on this account? Yes ♦ No ♦

N. **Health Insurance**

Is your child covered by health insurance? Yes ♦ No ♦ If yes, list below

Insurance Company Name & Address	Policy Number	Type of Coverage	Policy Ended
_____ _____ _____ Policy Holder Name _____	_____ Group Number _____ Policy Began ___/___/___	♦ Inpatient Hospital ♦ Outpatient ♦ Dental ♦ Cancer ♦ Medicare Supplement ♦ Other (i.e. prescriptions, Workman's Compensations	___/___/___ Employer Name (if have group insurance) _____

Insurance Company Name & Address	Policy Number	Type of Coverage	Policy Ended
_____ _____ _____ Policy Holder Name _____	_____ Group Number _____ Policy Began ___/___/___	♦ Inpatient Hospital ♦ Outpatient ♦ Dental ♦ Cancer ♦ Medicare Supplement ♦ Other (i.e. prescriptions, Workman's Compensations	___/___/___ Employer Name (if have group insurance) _____

Is your child covered by health insurance? Yes ♦ No ♦ If yes, list below

Father's employer _____

Mother's employer _____

If there is no insurance coverage for your child, please explain why not:_____

_____

O. **Other Information**

Please add any other information or comments about your child's care and/or costs of care which you would want the Department of Social Services to know when determining program eligibility for your child.

_____

_____

_____

_____

◊ Certification of Citizenship or Alien Status

The Immigration Reform and Control Act (Public Law 99-603), as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, requires every person applying for Food Stamps, TANF, or Medical Assistance to provide a declaration of citizenship or alien status. Any person who refuses or chooses not to provide information about their citizenship or alien status will not be eligible for benefits, however the individual may be required to answer questions and submit verifications about his or her income/resources, etc. The individual's information may affect the eligibility and/or benefit level of the household. EXCEPTION: Emergency medical assistance may be available regardless of citizenship, immigration status, or having a Social Security Number.

Proof of United States citizenship must be provided for each individual applying for Food Stamps, TANF, or Medical Assistance if citizenship is questionable. Non-citizens applying for or receiving benefits will need to show documentation of immigration status from the Immigration and Naturalization Service (INS). This proof will be verified by the Department of Social Services through INS. Information received from INS may affect your household's eligibility and level of benefits.

For all members required to state their citizenship or alien status, an adult household member (18 years or age and over) must sign below certifying each member's U.S. citizenship or alien(s) in satisfactory immigration status.

List Your Child's Name	Status*	Signature of Parent	Date

*List status such as: Citizen, Lawful Alien, Student, Visa, etc.

" 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 eligibility.

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 Medicaid case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

"ASSIGNMENT OF MEDICAL SUPPORT AND INSURANCE PROCEEDS

An application for and acceptance of medical assistance paid from the Department of Social Services is an assignment of any rights to medical support, insurance proceeds, or both that your child may have. We need information about private health insurance so we can make sure your private health insurance has paid the portion of your bill that it covers. Medicaid does not pay medical expenses that a third party is supposed to pay.

" COOPERATION REQUIREMENTS

I understand that by applying for Medicaid benefits, I agree to cooperate with the state Medicaid agency in identifying and providing information to help pursue any third party who may be responsible for paying for care and services for my child (or for a person on whose behalf I am applying) that are covered by Medicaid, or enabling third party payments to be made for my child (or on behalf of another person). If necessary, I also agree to establish paternity for any children for whom I am applying for Medicaid benefits.

″ ESTATE RECOVERY AND MEDICAL ASSISTANCE LIENS

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 the mentally retarded; 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 applicant indicated below. 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 the mentally retarded, 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 home or other facility if the resident was receiving medical assistance from the Department at the time of death.

″ 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 his civil rights have been violated may request a fair hearing. You may also file a complaint of discrimination by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or calling (605) 773-3305.

″ FAIR HEARINGS

Any applicant for, or recipient of, public assistance whose application for assistance is denied or who disagrees with any action affecting receipt, suspension, reduction or termination of assistance benefits may appeal such action. You may request a fair hearing by filing a request, either orally or in writing, with the Department of Social Services, 700 Governor's Drive, Pierre, South Dakota 57501 -2291. Phone number 605-773-4678. A request for a fair hearing must be made within thirty (30) days after you receive your notice of action. At the fair hearing you may present your case yourself or with the assistance of others including legal counsel. The cost of legal counsel will not be the responsibility of the department.

″ FRAUD

Obtaining assistance by fraud from public assistance or related programs is prohibited. It is unlawful for any person to knowingly make or execute a false statement, instrument, document, or representation, or to use any other fraudulent device, and thereby obtain assistance to which he is not entitled from any program provided for by titles 26, 27A, 27B, or 28 of the South Dakota Codified Law, or otherwise administered by the South Dakota Department of Social Services.

Section 1909 of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with your application for or receipt of Medicaid benefits. You may be prosecuted in Federal Court for deliberate

statements which you know to be false and which affect your eligibility (or for a person on whose behalf you are applying) for any benefit or payment under the Medicaid program. You may also be prosecuted for concealing or failing to disclose any event of which you may have knowledge which affects your right (or for a person on whose behalf you are applying) to any benefit or payment or its conversion to the use of someone else. In addition, the law provides a penalty for kickback, bribe or rebate in connection with the furnishing of Medicaid benefits. Penalties are fines up to $25,000 or imprisonment for up to five years or both. Conviction of an offense could result in loss of Medicaid benefits for a period not to exceed one year.

″ AUTHORIZATION TO FURNISH INFORMATION 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.

″ SIGNATURE

_____

Signature of Parent or Legal Guardian Date