State of South Dakota – Department of Social Services

Application for Medical Assistance for Workers with Disabilities

Fill in the circles like this ○ - ●

Section A

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.

Please use dark ink. Please print. If you need more room, add pages	**Applicant** The person applying for benefits	**Spouse**
What benefits are you applying for?	○ Assisted Living ○ In Home Services ○ Family Support Waiver ○ Nursing Facility ○ Hospitalization ○ Group Home ○ Resource Assessment ○ Other/Unknown	
First Name	_____	_____
Middle Name	_____	_____
Last Name	_____	_____
Gender	○ Male ○ Female	○ Male ○ Female
Social Security Number		
Birth Date (MM, DD, YYYY)		
Marriage Status (mark one)	○ Married ○ Divorced ○ Widowed ○ Single ○ Separated	**If divorced, list date:** _____
If deceased, date (mm, dd, yyyy)		
Current Address	_____	_____
City	_____	_____
State, ZIP	_____	_____
Phone Number	_____	_____
Mailing Address	_____	_____
City	_____	_____
State, ZIP	_____	_____
County	_____	_____

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 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 16.

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

What month are you requesting assistance from Medicaid to start?

_____
Month

_____
Name of your primary care physician and location

Section E

Resources/ Assets

Reminder:

Answer the questions for you.

Please provide the most recent 3 months of bank statements

If you need more room, copy the pages.

Resources/Assets – Complete questions below for yourself. Include all your resources/assets, and those owned jointly with anyone.

Checking account owned by you? ○ Yes ○ 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

Savings account owned by you? ○ Yes ○ 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

Section E

Resources/ Assets (continued)

Reminder: Answer the questions for you

If you need more room, copy the pages.

Employee payroll debit card or Direct Express Federal Benefits cards owned by you? ○ Yes ○ 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? ○ Yes ○ 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? ○ Yes ○ No

Account 1

Account Number	Names on account	
Bank or company name		Value
City	State Zip	Phone

Section E

Resources/ Assets (continued)

Stocks or mutual funds owned by you? ○ Yes ○ 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? ○ Yes ○ 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? ○ Yes ○ No

Account 1

Account Number	Names on account	
Bank or company name		Value
City	State / Zip	Phone

Please read the annuity disclosure information and information concerning when the state shall be named beneficiary of an annuity provided on page 17.

Section E

Resources/ Assets (continued)

Any other account owned by you? ○ Yes ○ No

Account 1

Account Number	Names on account
Bank or company name	Value
City State Zip	Phone

Reminder:

Answer the questions for you.

Cash on hand? ○ Yes ○ No

If yes, how much cash: _____

Life Insurance owned by you? ○ Yes ○ No

Name of insured person (first, middle, last)	Name of policy owner
Policy Number	Insurance Company
Company Address City State Zip Code	
Phone:	
How much is the premium?	Who pays the premium?
○ Monthly ○ Quarterly ○ Yearly 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:	
How much is the premium?	Who pays the premium?
○ Monthly ○ Quarterly ○ Yearly How often is the premium paid?	

Section E

Resources/ Assets (continued)

Do you have any financial arrangements such as contracts, insurance, or accounts designated for burial? ○ Yes ○ 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 named in any trusts or have ownership in any trusts? If yes, give facts below and provide a copy of the trust. ○ Yes ○ No

Owner/name of trust	Values

Reminder:

Provide copies of Liens and registrations.

Do you have any cars, trucks, boats, or other recreational vehicles? ○ Yes ○ No

Make/Model	Year	value
Owner	Amount owed	Primary use
Make/Model	Year	Value
Owner	Amount owed	Primary use

Do you own a home (includes mobile)? ○ Yes ○ 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? ○ Yes ○ No

Please provide a copy of the latest real estate tax statement.

Do you have a reverse mortgage on your home? ○ Yes ○ No

Did you receive lump sum? ○ Yes ○ No If yes, how much? _____

Do you receive a monthly payment? ○ Yes ○ No If yes, how much? _____

Section E

Things You are Paying for or Own

Do you own or share ownership of any other land, lots, or real estate? ○ Yes ○ No
If yes, list property address/county below.

Address or location	Value

Do you have a life estate or remainder interest in property? If yes, list property address/county below. ○ Yes ○ No

Address or location	Amount of land	Value

Provide a copy of contract.

Do you have any promissory notes, mortgage notes or a contract for deed? ○ Yes ○ No
If yes, provide a copy of the contract.

The terms are: ○ Negotiable ○ Non-negotiable Value: _____

Do you have mineral, oil, gas, timber, wind, or surface rights? ○ Yes ○ No
If yes, please complete below:

Owner	Address or location	Type	Value

Do you own any business equipment, machinery, livestock, antiques, collections other than household furnishings? ○ Yes ○ No

Item	Value

Do you hold any interest in a partnership or corporation? If yes, list below: ○ Yes ○ 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
If yes, mark the type	○ Part A ○ Part B ○ 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?

○ Monthly ○ Quarterly ○ 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?

○ Monthly ○ Quarterly ○ Yearly How often is the premium paid?

Do you get this insurance through a job you had or have? ○ Yes ○ 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?
○ Yes ○ No
_____ If yes, what is the monthly amount?
Do you get Supplemental Security Income?
○ Yes ○ No
_____ If yes, what is the monthly amount?
Are you a veteran?
○ Yes ○ No
Do you get veteran's benefits?
○ Yes ○ No
_____ If yes, what is the monthly amount?
_____ Claim number
Do you get railroad retirement benefits?
○ Yes ○ No
_____ If yes, what is the monthly amount?
_____ Claim number
Do you get civil service retirement payments?
○ Yes ○ No
_____ If yes, what is the monthly amount?
_____ Claim number
Do you get any other retirement or pension payments?
○ Yes ○ 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?
○ Yes ○ 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
○ Yes ○ 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 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
○ Social Security
○ Supplemental Security Income (SSI)
○ Veteran's benefits
○ 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?

○ **Yes** ○ **No**

If you checked yes, the Department of Social Services will send you a voter registration form. Return the completed registration card 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.

Please note that the information and office to which application was made will remain confidential and be used 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 From 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

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 chance 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	