South Carolina Department of Health and Human Services Family Planning Application

Application Date:

1. **Tell us who you are and where you live.**

Name (First, Middle Initial, Last):	**Social Security Number**: (Required)	**Place of Birth:** (City, County, State)
Home Address (include apartment number): **City**: **State**: **Zip Code**:		**County**:
Mailing Address (if different from above): **City**: **State**: **Zip Code**:		**Telephone Number**: ( )
What is your primary language? ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other ____________	**Your Full Name at Birth**:	**Your Mother's Full Maiden Name**:

2. **Do you have health insurance that covers doctor visits and lab tests?** ☐ **YES** ☐ **NO** *If yes, complete the following:*
   Name of Company ______________________ Policy Number ______________________ Insured's Name ______________________
3. **Are you currently receiving Medicaid?** ☐ **YES** ☐ **NO** If yes, do you have a Medicaid card with you? ☐ **YES** ☐ **NO**
4. **Are you currently a student?** ☐ **YES** ☐ **NO** **Name of School:** ______________________ **Grade/Year:** ______________
5. **Tell us information about you and other family members who live with you:** Social Security Numbers are not required for persons who are not applying for Medicaid.
   If you tell us the Social Security Numbers, it may help us process your application faster.

NAME	RELATIONSHIP	BIRTHDATE	RACE	SEX	US CITIZEN?	SC RESIDENT?	MARITAL STATUS	SOCIAL SECURITY NUMBER
1.	Applicant							
2.								
3.								
4.								
5.								
6.								
7.								

6. **Do you or anyone in your family have income from work or any other source?** ☐ **YES** ☐ **NO** *If yes, complete the following:*
   Please provide proof of last 4 weeks of income if applying for full Medicaid benefits.

NAME OF PERSON WHO GETS THE INCOME	SOURCE OF INCOME (Social Security, Child Support, etc.)	GROSS MONTHLY INCOME
1.		
2.		
3.		
4.		

7. **Do you pay someone to take care of your child(ren) under age 12?** ☐ **YES** ☐ **NO** *If yes, complete the following:*
Please provide proof of last 4 weeks payment if applying for full Medicaid benefits.

NAME OF CHILD(REN) RECEIVING CARE (Please attach a sheet for additional children)		
Name: ____________	Name: ____________	Name: ____________
1a. How much? ________ 1b. Frequency ________	2a. How much? ________ 2b. Frequency ________	3a. How much? ________ 3b. Frequency ________

8. **Did you receive medical services in the past 3 months?** ☐ **YES** ☐ **NO**

   Which month(s)? ________________________ Income information must be provided for each month retroactive coverage is requested

9. **Family Planning is a limited benefit program; would you like to apply for full benefits under any other Medicaid program?** ☐ **YES** ☐ **NO**

(The signatures of Applicant, Authorized Representative, Parent and/or Guardian below indicate that the Rights and Responsibilities on Page 3 have been read. When applicable, both the Applicant and Authorized Representative should sign the application.)

Applicant's Signature____ Date______________

Authorized Representative's Signature____ Date______________

MAIL YOUR SIGNED FAMILY PLANNING APPLICATION TO THE LOCAL MEDICAID ELIGIBILITY OFFICE IN YOUR COUNTY.

If you have questions or need help locating your local eligibility office, please call:
1-888-549-0820 (toll-free number)

DHHS USE ONLY

Gross Monthly Earned Income		________
Standard Deduction	–	________
Gross Unearned Income	+	________
Child Care Deduction	–	________
Net Family Income	=	________
Income Limit		________

- DHHS/DHEC USE ONLY -

I have reviewed the statements on this form with the applicant/beneficiary.

DHHS/DHEC Worker's Signature ________________________________ **Date** ________________

Telephone, including Area Code________________________________ **Location**________________

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Healthy Connections Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

9. I have read the Rights and Responsibilities, or they have been read to me.

10. By signing this application, I certify that the information I have provided to DHHS is true and accurate to the best of my knowledge.

11. I authorize the release of any information necessary to establish my family's eligibility. I authorize the copying of this signature page to be used as a release form to verify information. It shall remain valid and in force until: revoked by me in writing; my application has been denied; or my case has been closed.

Please tell us where you obtained this application ______________________________