

# State of South Dakota – Department of Social Services

## Application for Resource Assessment, Long Term Care or Related Medical Assistance

### Section A

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

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

### 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?  | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| Plan to stay in South Dakota?  | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| Hispanic or Latino? (optional)   | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| Race (optional)  | <input type="checkbox"/> Native American or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Hawaiian or Pacific Islander<br><input type="checkbox"/> White |                             | <input type="checkbox"/> Native American or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Hawaiian or Pacific Islander<br><input type="checkbox"/> 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? | <input type="checkbox"/> Yes   | <input type="checkbox"/> No | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
|  |  |                             |  |                             |

## Section B

### Citizenship

Provide citizenship documentation if not a US citizen.

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



**Section D**

**Your Home  
or Where  
You Live**

| Where do you live?   |  |
|--|--|
| Applicant  | Spouse   |
| <input type="checkbox"/> Nursing home  | <input type="checkbox"/> Nursing home  |
| <input type="checkbox"/> Assisted living center  | <input type="checkbox"/> Assisted living center  |
| <input type="checkbox"/> Group home for people with intellectual or developmental disabilities (ICF/IID) | <input type="checkbox"/> Group home for people with intellectual or developmental disabilities (ICF/IID) |
| <input type="checkbox"/> Your own home   | <input type="checkbox"/> Your own home   |
| <input type="checkbox"/> With someone else in their home   | <input type="checkbox"/> With someone else in their home   |
| <input type="checkbox"/> House paid for by someone else  | <input type="checkbox"/> House paid for by someone else  |
| <input type="checkbox"/> Other   | <input type="checkbox"/> Other   |

| Applicant   |   |  |  |  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|--|--|--|
| If you live in a facility, or expect to admit to a facility, please fill out below:   |   |  |  |  |  |  |  |  |  |  |  |
| Name of facility and location: _____  |   |  |  |  |  |  |  |  |  |  |  |
| Admission Date (mm, dd, yyyy) :   | <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |  |
| Discharge date (mm, dd, yyyy):  | <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |  |
| Were you in the hospital before moving to a facility or getting services in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |  |  |  |  |  |  |  |  |
| If yes, the date you entered the hospital or started getting services in your home.   |   |  |  |  |  |  |  |  |  |  |  |
| Date (mm, dd, yyyy):  | <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |  |
| Have you been private paying for your care? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |  |  |  |  |  |  |  |
| If yes, for how many months?  |   |  |  |  |  |  |  |  |  |  |  |
| _____   |   |  |  |  |  |  |  |  |  |  |  |
| Number of Months  |   |  |  |  |  |  |  |  |  |  |  |
| Do you have any unpaid medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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

**Reminder:**

Answer the questions for you and/or your spouse.

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 and your spouse. Include all your resources/assets, and those owned by your spouse or owned jointly with anyone.

**Checking account owned by you or your spouse?**  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 or your spouse?**  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            |

**Nursing home account owned by you or your spouse?**  Yes  No

|  |       |
|--|-------|
| _____  | _____ |
| Name of the place that keeps this fund for you | Value |
| _____  | _____ |
| City State Zip                                 | Phone |

**Section E**

**Resources/  
Assets  
(continued)**

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

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

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

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

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

|   |  |   |          |
|---|--|---|----------|
| <b>Life Insurance owned by you or your spouse?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |          |
| _____   |  | _____   |          |
| Name of insured person (first, middle, last)  |  | Name of policy owner  |          |
| _____   |  | _____   |          |
| Policy Number   |  | Insurance Company   |          |
| _____   |  |   |          |
| Company Address   |  | City  | State    |
|   |  |   | Zip Code |
|   |  |   |          |
|   |  | Phone:  |          |
|   |  |   |          |
| _____   |  | _____   |          |
| Face Value/Cash Value   |  | Type of Policy  |          |
|   |  | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly<br>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:  |          |
|  |  |   |          |
| _____  |  | _____   |          |
| Face Value/Cash Value                        |  | Type of Policy  |          |
|  |  | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly<br>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?**  Yes  No  
If yes, list below and provide a copy.

|   |                              |       |
|---|------------------------------|-------|
| _____   | _____                        | _____ |
| Where? (Applicant)  | Date purchased<br>(mm/dd/yy) | Value |
| _____   | _____                        | _____ |
| Where? (Spouse)   | Date purchased<br>(mm/dd/yy) | Value |
| <b>Are you or your spouse named in any trusts or have ownership in any trusts?</b> If yes, give facts below and provide a copy of the trust. <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |       |
| _____   | _____                        |       |
| Owner/name of trust   | Values                       |       |

#### Reminder:

Answer the questions for you and/or your spouse.

**Do you or your spouse 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 or your spouse 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? <input type="checkbox"/> Yes <input type="checkbox"/> No |             |       |

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

|   |  |                         |
|---|--|-------------------------|
| Do you have a reverse mortgage on your home? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                         |
| Did you receive lump sum?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how much? _____ |
| Do you receive a monthly payment?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how much? _____ |

## Section E

### Things You and Your Spouse are Paying for or Own

(continued)

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

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

Provide a copy of contract.

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

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

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

|  |  |
|--|--|
| <b>Do you or your spouse hold any interest in a partnership or corporation?</b> If yes, list below: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| _____  |  |
| Name of partnership/corporation  |  |



If this is a resource assessment only, you can skip the rest of the questions. Just go to page 22 and sign the form.

## Section F

### Tell Us About Your Household

#### Dependents

Tell us about children, or other dependents, living with you.

|                 |                               |        |        |  |
|-----------------|-------------------------------|--------|--------|--|
| <b>Person 1</b> | Name _____ Relationship _____ |        |        | Is this person disabled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 | Birth date (mm/dd/yyyy)       |        |        | Social Security Number   |
|                 | Income (gross)                | Source | Amount | Frequency  |
|                 |                               |        |        |  |
| <b>Person 2</b> | Name _____ Relationship _____ |        |        | Is this person disabled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 | Birth date (mm/dd/yyyy)       |        |        | Social Security Number   |
|                 | Income (gross)                | Source | Amount | Frequency  |
|                 |                               |        |        |  |
| <b>Person 3</b> | Name _____ Relationship _____ |        |        | Is this person disabled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 | Birth date (mm/dd/yyyy)       |        |        | Social Security Number   |
|                 | Income (gross)                | Source | Amount | Frequency  |
|                 |                               |        |        |  |

#### Housing costs

Do you or your spouse 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).

|                       | Applicant pays: | Spouse pays: | Other – List Name<br>_____ |
|-----------------------|-----------------|--------------|----------------------------|
| Rent or house payment |                 |              |                            |
| Tax on home           |                 |              |                            |
| Utilities             |                 |              |                            |
| Home insurance        |                 |              |                            |

## Section G

### Medical Facts

#### Medicare

Do you or your spouse have Medicare? If yes, please complete below:  Yes  No

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

#### LTC Insurance

Do you or your spouse 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="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly |       |
|  |                       | How often is the premium paid?  |       |

**Reminder:**  
Provide a copy  
of cards.

**Health Insurance:** Do you or your spouse 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="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly |                  |
|   |                           | How often is the premium paid?  |                  |
| Do you get this insurance through a job you had or have? <input type="checkbox"/> Yes <input type="checkbox"/> No |                           | If yes, list employer's name  |                  |

## Section H

### Money or Property You or Your Spouse Sold, Traded, or Gave Away

In the last 60 months have you, your spouse, or anyone on behalf of you or your spouse (i.e. family members, power of attorney, guardian, or conservator), transferred, given away, gifted, loaned, sold or deeded anything of value, such as money, land, buildings, home property, etc.?

Yes  No

|   |       |                                 |
|---|-------|---------------------------------|
| _____                                   | _____ | _____                           |
| What did you sell, trade, or give away? | Value | What did you get in return?     |
| _____                                   |       | _____                           |
| Who did you sell, trade, or give it to? |       | Date sold/given away (mm/dd/yy) |

|   |       |                                 |
|---|-------|---------------------------------|
| _____                                   | _____ | _____                           |
| What did you sell, trade, or give away? | Value | What did you get in return?     |
| _____                                   |       | _____                           |
| Who did you sell, trade, or give it to? |       | Date sold/given away (mm/dd/yy) |

Did you give up the right to get any money (including income) or an inheritance in the last 60 months?  Yes  No If yes, explain:

|       |
|-------|
| _____ |
| _____ |
| _____ |

In the last 60 months have you, your spouse, or anyone on behalf of you or your spouse (i.e. family members, power of attorney, guardian, or conservator) established a joint ownership in any real property owned by either you or your spouse?  Yes  No

|                        |                  |
|------------------------|------------------|
| _____                  | _____            |
| Name of Joint Owner    | Type of Property |
| _____                  | _____            |
| Address of Joint Owner | Date (mm/dd/yy)  |
| _____                  | _____            |
| Name of Joint Owner    | Type of Property |
| _____                  | _____            |
| Address of Joint Owner | Date (mm/dd/yy)  |

## Section H

### Money or Property You or Your Spouse Sold, Traded, or Gave Away

(continued)

In the last 60 months, has a joint owner taken possession of their share in any of your or your spouse's asset such as money, savings accounts, checking accounts, certificates of deposits, bonds, stocks, or anything else of value?  Yes  No

|                                 |                           |
|---------------------------------|---------------------------|
| _____<br>Name of Joint Owner    | _____<br>Type of Property |
| _____<br>Address of Joint Owner | _____<br>Date (mm/dd/yy)  |
| _____<br>Name of Joint Owner    | _____<br>Type of Property |
| _____<br>Address of Joint Owner | _____<br>Date (mm/dd/yy)  |

In the last 60 months were any of your or your spouse's funds or property placed into trust for you, your spouse, or anyone else?  Yes  No

|                             |  |
|-----------------------------|--|
| _____<br>Name of Trustee    | _____<br>Type of Property                |
| _____<br>Address of Trustee | _____<br>Date placed in trust (mm/dd/yy) |
| _____<br>Name of Trustee    | _____<br>Type of Property                |
| _____<br>Address of Trustee | _____<br>Date placed in trust (mm/dd/yy) |

Is any of your income paid directly into a trust?  Yes  No

|                             |  |
|-----------------------------|--|
| _____<br>Name of Trustee    | _____<br>Source of Income                  |
| _____<br>Address of Trustee | _____<br>Date trust established (mm/dd/yy) |
| _____<br>Name of Trustee    | _____<br>Source of Income                  |
| _____<br>Address of Trustee | _____<br>Date trust established (mm/dd/yy) |

## Section I

### 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  | Spouse   |
| <b>Do you or your spouse get Social Security?</b>                          |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | _____  |
| If yes, what is the monthly amount?  | If yes, what is the monthly amount?                      |
| <b>Do you or your spouse get Supplemental Security Income?</b>             |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | _____  |
| If yes, what is the monthly amount?  | If yes, what is the monthly amount?                      |
| <b>Are you or your spouse a veteran?</b>                                   |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Do you or your spouse get veteran's benefits?</b>                       |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | _____  |
| If yes, what is the monthly amount?  | If yes, what is the monthly amount?                      |
| _____  | _____  |
| Claim number   | Claim number   |
| <b>Do you or your spouse get railroad retirement benefits?</b>             |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | _____  |
| If yes, what is the monthly amount?  | If yes, what is the monthly amount?                      |
| _____  | _____  |
| Claim number   | Claim number   |
| <b>Do you or your spouse get civil service retirement payments?</b>        |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | _____  |
| If yes, what is the monthly amount?  | If yes, what is the monthly amount?                      |
| _____  | _____  |
| Claim number   | Claim number   |
| <b>Do you or your spouse get any other retirement or pension payments?</b> |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | _____  |
| If yes, what is the monthly amount?  | If yes, what is the monthly amount?                      |
| _____  | _____  |
| Source   | Source   |
| _____  | _____  |
| What is the claim number?  | What is the claim number?                                |

## Section I

### Money Coming into Your Home

| Applicant   | Spouse   |
|---|--|
| <b>Do you or your spouse get any payments from annuities?</b>   |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____   | _____  |
| If yes, what is the monthly amount?   | If yes, what is the monthly amount?                      |
| _____   | _____  |
| Company   | Company  |
| _____   | _____  |
| What is the claim number?   | What is the claim number?                                |
| _____   | _____  |
| <b>Do you or your spouse get dividends from stock, bonds or insurance?</b>  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____   | _____  |
| If yes, what is the amount?   | If yes, what is the amount?                              |
| _____   | _____  |
| How often?  | How often?   |
| _____   | _____  |
| Source  | Source   |
| _____   | _____  |
| <b>Do you or your spouse get rental income?</b>   |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____   | _____  |
| If yes, what is the amount?   | If yes, what is the amount?                              |
| _____   | _____  |
| How often?  | How often?   |
| _____   | _____  |
| <b>Do you or your spouse expect to get money from:<br/>- a lawsuit – a personal injury settlement – an accident liability claim – an inheritance?</b> |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____   |  |
| If yes, please list the name and phone number of a person who can tell us about the settlement.   |  |
| <b>Do you or your spouse get money from leases or royalties from oil, gas, mineral, wind, timber or surface rights?</b>                               |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____   | _____  |
| If yes, what is the amount?   | If yes, what is the amount?                              |
| _____   | _____  |
| How often?  | How often?   |
| _____   | _____  |
| <b>Are you self-employed?</b>   |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____   | _____  |
| Gross income amount   | Gross income amount                                      |
| _____   | _____  |

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



## Section I

### Money Coming into Your Home

(continued)

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

## Section J

### Programs You've Applied For

| <b>Money you or your spouse might get from other programs</b>  |   |
|--|---|
| Are you waiting for an answer on an application for one of the programs listed below?<br>Mark any that apply |   |
| Applicant  | Spouse  |
| <input type="checkbox"/> Social Security   | <input type="checkbox"/> Social Security                    |
| <input type="checkbox"/> Supplemental Security Income (SSI)  | <input type="checkbox"/> Supplemental Security Income (SSI) |
| <input type="checkbox"/> Veteran's benefits  | <input type="checkbox"/> Veterans' benefits                 |
| <input type="checkbox"/> Other benefits _____  | <input type="checkbox"/> 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 protected health information to the following individual/facility. My date of birth is \_\_\_\_\_

Individual/Facility and Name of Facility Person to Receive Information: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

This authorization is for the time period from: \_\_\_\_\_ to \_\_\_\_\_. If left blank, this authorization shall expire 1 year from the date of execution.

I allow DSS-EA to release only the following checked information to the above strategy: (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) \_\_\_\_\_
- Copy of Verification Checklist Form (EA-264) Dated: Month(s) \_\_\_\_\_ Year(s) \_\_\_\_\_

Purpose of this disclosure: \_\_\_\_\_

I understand if this information is released to a third part, the information may be released by the person or entity that receives that information may no longer be protected by federal or other applicable privacy regulations.

I understand that I may revoke this authorization, except to the extent that staff has already taken action upon it, by sending written notice to the Department of Social Services, Division of Economic Assistance, 700 Governors Drive, Pierre, SD 57501.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Individual Signing

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone

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>.

## 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. ကညီ(Karen) - ဟ်သုာ်ဟ်သး-နမ့ာ်ကတိာ် ကညီတျီာ်အယိ, နမန့ာ် ကျီာ်အတာ်မၤစၢလၢ တလၢာ်ဘျီာ်လၢာ်စ့ၤ နီတမံၤဘျီာ်သ့န့ၢ်လီၤ. 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) - यान ~दनुहोस: ो तपाइ~ले नेपाल~ बो नह छ भन तपाइ~को ~िनि त भाषा सहायता सवाह ~न:श क पमा उपल ध छ । फोन गनुहोसर् ो 1-800-305-9673 (~ट~टवाइ: 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) - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚክተለው 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 800-305-9673 (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](mailto: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.

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 recovery, estate recovery, 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            |             |
|---|-------------|-------------------|-------------|
|   |             |                   |             |
| <b>Sign above</b>   | <b>Date</b> | <b>Sign above</b> | <b>Date</b> |
|   |             |                   |             |
| <b>Print name</b>   |             | <b>Print name</b> |             |
| If you are a parent, guardian, authorized representative, court appointed administrator, executor, or have power of attorney for this person, sign below: |             |                   |             |
|   |             |                   |             |
| <b>Sign here (must provide proof)</b>   |             |                   | <b>Date</b> |
|   |             |                   |             |
| <b>Sign here if you are a witness</b> (only needed if anyone above signed with an “X” or other mark)  |             |                   | <b>Date</b> |
|   |             |                   |             |
| <b>Printed name of witness</b>  |             |                   |             |