SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Waiver Client Status Form

There are two preferred methods to submit the documents to SCDHHS:
Email: 8032558296@fax.scdhhs.gov OR Fax: (803) 255-8296 - Send a separate fax for each applicant/member.

Attn:	**From:**
Initial Entry: ☐PACE ☐ HASCI ☐ID/RD ☐CSW	**Date of Transfer:** ___/____/___ MM DY YYYY
Transfer From: ☐PACE ☐ HASCI ☐ ID/RD ☐CSW ☐ CC ☐ MCC ☐ CHPC ☐ VENT ☐ HIV **Transfer To:** ☐PACE ☐ HASCI ☐ ID/RD ☐CSW ☐ CC ☐ MCC ☐ CHPC ☐ VENT ☐ HIV	
Declination or Termination: ☐Pace ☐ HASCI ☐ID/RD ☐CSW	**Date:** __/___/___ MM DY YYYY **Reason:**

Part I - Client Information (To Be Completed by DDSN/PACE)

Client Name (First, Middle, Last)		**Birth Date (MM-DD-YY)**		
Medicaid Number (10 digits)	**Pay Category**	**Social Security Number**		**Sex**
Client Address		**City**	**State**	**ZIP**
Location ☐ Home ☐ Hospital ☐ CRCF ☐ Nursing Facility/ICF		**Client Phone Number**		
Responsible Party		**Responsible Party Phone Number**		
Responsible Party Address		**City**	**State**	**ZIP**
CM/EI:	**Provider Name:**		**Provider Number:**	
Provider Address		**City**	**State**	**ZIP**

DHHS 1296-ER completed for SSI beneficiary? ☐ Yes ☐ No

EC Signature	**Today's Date**

Part II- Medicaid Eligibility Status
(To be completed by Medicaid Eligibility Worker for Initial Entries. Please check all boxes that apply.)

☐ Current Medicaid Beneficiary. *Look back completed.*
☐ Income Trust ☐ Yes ☐ No
☐ Not eligible for waiver services due to non-cooperation
☐ Not eligible for waiver or other long-term care services due to a transfer
☐ The above-named recipient has been determined to be financially eligible; except for level of care (LOC), but his/her case cannot be certified until the 30 consecutive days requirement is met.
☐ Other: _____
Verified Medicaid Number _____ Payment Category _____ Application Date_____

Medicaid Eligibility Worker Name	**Date**

Part III- Notification of Waiver Services

Level of Care: ☐NF/Intermediate ☐NF/Skilled ☐ICF/IID	**Date Level of Care Determined:** ___/____/____ MM DY YYYY
Enrollment Date: ___/____/___ MM DY YYYY	
Individual did not complete 30 consecutive days due to:	
Signature	**Date**