

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTENT TO RETURN HOME STATEMENT

INSTRUCTIONS: This form is to be completed and signed by the patient or the patient's legal guardian or authorized representative and filed in the case record as documentation.

_____ owns homestead property located
(Name of Patient)
at _____, _____,
(Street) (City)
_____, _____.
(County) (State)

Although the aforementioned individual is not currently residing in the above designated homestead property, he/she or his/her authorized representative has been interviewed and he/she has stated that it is his/her or the patient's intent to:

Check
one of
these
boxes }

☐

return home

☐

not return home

(Date)

(Signature of Patient or Authorized Representative)

(Date)

(Signature of Medicaid Eligibility Worker)

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (including large print, braille, audio, accessible electronic formats, and other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS 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 grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are 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 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>