

**South Carolina Department of Health and Human Services**  
**Application for South Carolina Healthy Connections**  
*Coverage for Children, Pregnant Women, and Families*

**Note:** You only need to tell us the Social Security Number and answer the question about being a US citizen for the people for whom you are applying. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.

**1. Tell us about yourself (Primary Individual)**

<b>Name</b> (First, Middle Initial, Last):		<b>Social Security Number:</b> (not required for emergency services)		<b>Date of Birth:</b>
<b>Address where you get mail</b> (include apartment number)		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Home Address</b> (if not the same as your mailing address)		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>US Citizen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Are you applying for yourself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Need retroactive coverage for the past three months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____
<b>If you are applying and are not eligible for regular Medicaid, do you want us to look at Family Planning?</b> <input type="checkbox"/> Include Family Planning Family Planning is a limited benefits program that provides Family Planning Services only. Family Planning services include birth control methods, permanent sterilization procedures (vasectomy and tubal ligation), lab work, examination, prescriptions, office visits, and counseling related to family planning.				
<b>Your Full Name at Birth:</b> This helps us verify citizenship		<b>County/State where you were born:</b>		<b>Your Mother's Full Name at her Birth:</b>
<b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<b>Are you Disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Are you Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Pregnant, Due Date:</b> _____		<b>Are you currently attending school?</b> <input type="checkbox"/> Yes What grade? _____ <input type="checkbox"/> No
<b>Do you have Health Insurance now?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Company Name _____ Policy ID# _____				
<b>Are you the parent, stepparent, or guardian of any of the children listed on the application?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>What language do you use most?</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:		<b>Race</b>	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Multi Race <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other/Unknown	

\* Proof of tribe membership is required

**2. Tell us about your spouse or other adult in the home who may be the parent or guardian of the children**

<b>Name</b> (First, Middle Initial, Last):		<b>Social Security Number:</b> (not required for emergency services)		<b>Date of Birth:</b>
<b>US Citizen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Need retroactive coverage for the past three months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Months Requested: _____
<b>If this person is not eligible for regular Medicaid, do you want us to look at Family Planning?</b> <input type="checkbox"/> Include Family Planning				
<b>Full Name at Birth:</b> This helps us verify citizenship		<b>County/State where born:</b>		<b>Mother's Full Name at her Birth:</b>
<b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<b>Are you Disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Are you Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Pregnant, Due Date:</b> _____		<b>Currently attending school?</b> <input type="checkbox"/> Yes What grade? _____ <input type="checkbox"/> No
<b>Does this person currently have Health Insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Company Name _____ Policy ID# _____				
<b>Is this person the parent, stepparent, or guardian of any of the children listed on the application?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Relationship to You?</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Boyfriend/Girlfriend <input type="checkbox"/> Other:		<b>Race</b>	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown	

\* Proof of tribe membership is required

**3. Tell us about the children who live with you.**

A Social Security Number is not required if applying for Emergency Services Only

	Child 1	Child 2	Child 3
<b>Full Name</b> (First, Middle, Last)			
<b>US Citizen</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Social Security Number</b>			
<b>Medicare or Social Security Claim Number</b>			
<b>Date of Birth of the Child</b>			
<b>City, County and State where the Child was born</b>			
<b>Sex</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Applying for Coverage</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mother's Full Name at her Birth</b>			
<b>Put a check for all that applies</b>	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____
<b>Race</b>  * Proof of tribe membership is required	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown
<b>Is the Child now attending school</b>	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No
<b>Relationship of the Child to the Primary Individual</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
<b>Relationship of the Child to the Spouse/Other Adult in the Home</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
<b>Does the Child get Child Support payments?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you pay someone for childcare for this Child while you work or attend school?</b>	Name of Provider or Daycare Center _____ _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Need retroactive coverage for the past three months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____
<b>Does the Child have Health Insurance now? (Do not include Medicaid)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give us a copy of the front and back of all health insurance cards.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give us a copy of the front and back of all health insurance cards.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give us a copy of the front and back of all health insurance cards.</i>
	If <b>Yes</b> , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____	If <b>Yes</b> , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____	If <b>Yes</b> , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____
<b>For each child shown above, if he or she is not eligible for regular Medicaid, do you want us to look at Family Planning?</b>	<input type="checkbox"/> Include Family Planning	<input type="checkbox"/> Include Family Planning	<input type="checkbox"/> Include Family Planning

	Child 4	Child 5	Child 6
<b>Full Name</b> (First, Middle, Last)			
<b>US Citizen</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Social Security Number</b>			
<b>Medicare or Social Security Claim Number</b>			
<b>Date of Birth of the Child</b>			
<b>City, County and State where the Child was born</b>			
<b>Sex</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Applying for Coverage</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mother's Full Name at her Birth</b>			
<b>Put a check for all that applies for the Child</b>	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____
<b>Race</b>  * Proof of tribe membership is required	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi Race <input type="checkbox"/> Other/Unknown
<b>Is the Child now attending school</b>	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____
<b>Relationship of the Child to the Primary Individual</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
<b>Relationship of the Child to the Spouse/Other Adult in the Home</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
<b>Does the Child get Child Support payments?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you pay someone for childcare for this Child while you work or attend school?</b>	Name of Provider or Daycare Center _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Need retroactive coverage for the past three months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____
<b>Does the Child have Health Insurance now? (Do not include Medicaid)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give us a copy of the front and back of all health insurance cards.</i> If <b>Yes</b> , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give us a copy of the front and back of all health insurance cards.</i> If <b>Yes</b> , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give us a copy of the front and back of all health insurance cards.</i> If <b>Yes</b> , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____
<b>For each child shown above, if he or she is not eligible for regular Medicaid, do you want us to look at Family Planning?</b>			
	<input type="checkbox"/> Include Family Planning	<input type="checkbox"/> Include Family Planning	<input type="checkbox"/> Include Family Planning

**4. Tell us about the income of each family member in the home.**

Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks.**

Your Income from Employment	Spouse/Other Adult's Income from Employment <i>(if living in the home)</i>
Name of person working _____	Name of person working _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
_____	_____
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? \$ _____	Gross amount earned per pay period before taxes? \$ _____
How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly

**Is anyone self-employed?**  Yes  No **If yes, you must send copies of all the most recently filed Personal and Business Federal income tax forms including all forms and schedules.**

Please name Self-Employment Business and/or Partnership: \_\_\_\_\_

**Does anyone in your home receive, or have applied for, any other income?**  Yes  No

If Yes, check all boxes that apply and complete the table below

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Social Security benefits (RSDI)   | <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Disability benefits      |
| <input type="checkbox"/> Pension/retirement benefits   | <input type="checkbox"/> Workers' compensation              | <input type="checkbox"/> Unemployment benefits    |
| <input type="checkbox"/> Veterans benefits   | <input type="checkbox"/> Money from friends or relatives    | <input type="checkbox"/> Rental Income            |
| <input type="checkbox"/> Military allotments   | <input type="checkbox"/> Room and/or board income           | <input type="checkbox"/> Interest/dividend income |
| <input type="checkbox"/> Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement) |   |   |
| <input type="checkbox"/> Other: _____  |   |   |

Person receiving/expecting money	Income source/type	How often received	Amount received	Expected to continue?	Date expecting, if not yet started
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**5. Are there any adults in the home who are not currently working?**  Yes  No

If Yes, tell us who and when they last worked: \_\_\_\_\_  
\_\_\_\_\_

**6. If your family does not have any income, explain how you pay your bills.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Does the equity value of all your assets add up to more than \$30,000? Do not count the value of the home you live in or up to \$20,000 of equity value per vehicle for each licensed driver.**

**Yes, my assets are over \$30,000**       **No, my assets are less than \$30,000**

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, a vehicle that is valued at \$5000, and \$2000 is still owed on it, has an equity value of \$3000.)

8. Do you pay court ordered child support for a child outside your home? (If yes, please provide proof)  Yes  No

Name of Child	How much do you pay?	How often do you pay this amount?

9. Do you pay someone to take care of a dependent adult while you work or attend school?  Yes  No

Name of Adult	Who do you pay?	How much do you pay?	How often do you pay?

**IMPORTANT**

- You must read and sign this form on the last page to complete your application.
- Below is a list of some types of information that can help us process your application faster. You do not have to wait to send in your application if you do not have something, but it may take us longer to make a decision. If we need something from you, we will send you a list to tell you exactly what we want.
  - Proof of Income
    - Copies of pay stubs for the **last 4 weeks for any adult person listed**; or a letter from employer that shows last 4 weeks of GROSS pay.
    - A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
    - Proof of all other income for the last 4 weeks, including child support.
 

**NOTE:** You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.
  - Proof of income for the past 3 months if you have received medical services and you want to find out if Medicaid can help pay.
  - If you are self employed, the most recent income tax forms including all schedules.
  - Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
  - United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, for each non-citizen applying for full Healthy Connections.
  - If applying for Emergency Services Only for someone who is not a citizen, the applicant is not required to provide USCIS documentation or a Social Security Number.
  - Original Documents of citizenship and identity for each US citizen applying for coverage. (If you have provided this information since July 1, 2006, you do not have to provide it again.)

*Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.*

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Healthy Connections beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a \$25 fee. I want to voluntarily apply for these services:  
 Yes  No

**Rights and Responsibilities**

1. I know that my children under age 19 who are eligible for 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 Healthy Connections 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 Healthy Connections Card(s).
  - a. I know that, in accordance with the federal rules governing the Healthy Connections 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 Healthy Connections 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' Medical Assistance programs, and the TANF and Food Stamp agency (Department of Social Services (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 Healthy Connections 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 Healthy Connections 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 Healthy Connections coverage.
  - 7. 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.  
  
If eligibility is for my child(ren) only, I am not required to report any changes in my situation, except for change of address. If I report any other changes in my situation, it will not affect their eligibility for benefits until the next scheduled review.
  - 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:
    - o Revoked by me in writing;
    - o My application has been denied; or
    - o My case has been closed.

*(If possible, both the Applicant and Authorized Representative should sign.)*

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If an Authorized Representative is completing this application, please complete the following:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_