South Carolina Department of Health and Human Services
Medically Indigent Assistance Program (MIAP)
Medicaid Addendum

THIS IS NOT A VALID MEDICAID APPLICATION UNLESS IT IS ATTACHED TO A COMPLETED MIAP APPLICATION.

1. List the family members that you listed on your MIAP application, starting with the MIAP applicant, and give the requested information for each one. *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 want Medicaid. However, if you give us your Social Security number, it may help us process your application faster. We only use Social Security numbers to help us verify your income.*

Last Name	**First Name**	**Middle Initial**	**Check (ü) if this person is applying for Medicaid**	(See note above) **Social Security Number**	**Sex**		**Race**	**Is this person pregnant?** (See Note 1 below.)		**Is this person disabled?**		**Is this person a foster child?**		**Is this person a US citizen?** (See Note 2 below)		**Has this person received medical services in the past 3 months?**	
					M	**F**		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**

Note 1: Date baby is due: _____ Provide proof of due date from doctor, nurse, or Health Department for each pregnant woman.
Note 2: Provide Bureau of Citizenship and Immigration Services (BCIS) documents for each non-citizen requesting coverage.

2. Do you pay someone to take care of your child(ren) under 12 and/or of a dependent adult in your home while your work, or do you pay court ordered child support for a child outside your household? o **No** o **Yes** _____ (Number of children under age 12 and/or dependent adults for whom you pay for care)

Name of child/dependent adult	**Age**	**Do you participate in the ABC (childcare) Voucher program?**	**How much do you pay for this care?**	**How often do you pay this amount?**	**Whom do you pay? Please give their name and telephone number.**

3. Tell us about any health insurance coverage covering anyone for whom you are applying, including Medicaid in another state.

Insurance Company or Employer	Policy Number	Policyholder's Name	Policyholder's SSN	Persons Covered	What type of coverage is this?	How much do you pay per month for this coverage?	Does your employer pay any of this cost?

4. Tell us what language you use most:

o English o Spanish o Chinese o Russian o Sign Language o Vietnamese o Other _____

If you are applying for someone who is age 65 or older or disabled, answer #5. If not, you can skip to #6

5. Does anyone in your family own the following?

Asset	Yes	No	Who owns it?	Value
Burial plots				**$**
Burial funds				**$**
Campers				**$**

6. Does anyone listed on this application already have a plastic Medicaid card? o **Yes** o **No**

If yes, list their name and Medicaid Health Insurance Number here: _____

7. You must sign one of these statements:

US Citizens or Lawful Immigrants

o I certify that the information I have provided is true to the best of my knowledge and I give permission for the State of South Carolina to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I could be penalized, and liable for prosecution, if I knowingly give false information. I certify that all persons for whom I am applying are U. S. citizens or lawful immigrants.

Signature of applicant or authorized representative: _____ Date: _____

Address and phone number of authorized representative, if applicable: _____

Non US Citizens

o I am not a citizen nor lawful immigrant. However in applying for payment of an emergency service, I certify that the information I have provided is true to the best of my knowledge.

Signature of applicant or authorized representative: _____ Date: _____

Address and phone number of authorized representative, if applicable: _____

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 Medicaid beneficiaries without charge. I understand that if I check (ü) "no" and ask for child support services later, I will have to pay a $25 fee.

I want to apply for these services now. o Yes o No

Rights and Responsibilities

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS 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 health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.
4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

[ ] I have read these rights and responsibilities or had them read to me:

Signature of Applicant or Authorized Representative: _____ Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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