SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Mail to:

Name (First, Last)

Street Address

City

State ZIP

Authorized Representative Name (First, Last)

Street Address

City

State ZIP

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.

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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

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Healthy Connections MEDICAID

Medicaid Eligibility Checklist

Name ____________________ Date ____________________

Household Number ____________________ Member ID Number ____________________

Authorized Representative (if applicable) ____________________

Please return this checklist along with the information requested below. To determine Medicaid eligibility, the Department of Health and Human Services will need the following items (marked with an **X**) for the applicant, spouse, and children under age 22.

☐ Tax Return – IRS Form 1040, 1040-EZ or 1040-A (Most recent, both personal and business (Schedule C) if applicable. Include entire return with all pages and schedule attachments.)

☐ Application / Addendum: DHHS Form ☐ 3400 ☐ 3400-A ☐ 3400-B ☐ 3400-01 ☐ 3401 ☐ 2800-A

☐ Verification of: ☐ Citizenship ☐ Identity (Originals not required. Please send photocopies.)

☐ Social Security Numbers for the following person(s) requesting Medicaid:

____________________ ____________________

____________________ ____________________

☐ DHHS Form 1282, Authorized Representative

☐ Power of Attorney or Court Order for Guardianship or Conservator Papers

☐ ____________________ will need a disability determination to possibly be eligible.
Please fill out the forms that are checked below. We may contact you for missing information.
DHHS Form: ☐ 3218 ME ☐3218-D ME ☐ 3266 ME ☐ 3266-D ☐ 921

☐ TEFRA (Disabled Children)
- ☐ DHHS Form 3291, In-Home Care Certification
- ☐ Permission to Evaluate Form (DDSN)

☐ Breast and Cervical Cancer Program (BCCP)
- ☐ Pathologist Report ☐DHHS Form 913-A, Application Addendum ☐ Progress Notes

☐ DHHS Form 3310, Statement of Pregnancy

☐ Proof of gross income received by: ____________________
from (date) ____________________ to (date) ____________________

____________________ ____________________

This may be a copy of an itemized check stub, award letter, printout, or statement on a letterhead from the company, agency, or payor.

☐ All bank or other financial account statements for ____________________
from (date) ____________________ to (date) ____________________
Please send entire financial account statements, not account summaries.

☐ Copies of applicant's/spouse's Trust agreements

☐ Copies of applicant's/spouse's: ☐ Pre-need burial contract(s) ☐ Burial plot deeds
You may send other verification such as a statement on letterhead. If the contract or plot is not paid for, please send verification of the amount paid to date.

☐ DHHS 1766 A, Burial Exclusion

☐ Verification of Life Insurance. Provide one of the following for the applicant/spouse:
- ☐ Copy of all policies ☐ DHHS Form 1280ME, Verification of Insurance Value
- ☐ Letter from agent showing policy number, owner name, face value and current cash value

☐ Proof of amount owed on real and personal property

☐ Year, make, and model of all motor vehicles

☐ All medical insurance policies or cards and proof of premiums

☐ Annual Review form

☐ Voter Registration Form or Voter Registration Declination Form.

These are not required for Medicaid eligibility. These are provided as a service to you.

Additional Needs for Applicants for Long-Term Care Services

☐ DHHS Form 1277, Intent to Return Home

☐ Income Trust Packet

☐ The income limit for institutional care is ____________________ for ___________________________

The applicant's income is over this amount. To possibly qualify for Medicaid assistance for long-term care services, an income trust must be established.

☐ Please sign and return DHHS Form 905, Income Trust Agreement

☐ Verification of bank account for Income Trust

Designate or establish a bank account for income to flow through and send verification of this account.

☐ Copy of: ☐ Annuity ☐ Promissory Note for ____

☐ Please sign and return DHHS Form:

☐ 943, Release of Information
☐ 1253 ME, Request for Financial Investigation
☐ 1212 ME, Verification of Veterans Information
☐ 1296 ER, Estate Recovery Notice

Provide the above information by _______________

Medical Records for Applicants requiring a Disability Determination

Some applicants may be asked for medical records. If so, someone may contact you and can help request them. They can also answer your questions about what medical records are needed. All medical records must be received within 45 days.

☐ Medical Records for the 15 months prior to ______________ for

Applicant: __________________________________ Client ID: _______________

Applicant: __________________________________ Client ID: _______________

Medical Records may include:

- Medical history
- Diagnoses
- Care or treatments received
- Medication taken
- Test results
- Therapy records
- Individualized Education Program (IEP) Records (Children under the age of 19)

Do not submit CDs, Flash Drives, Film, or Photocopies. They cannot be used as verification.

Comments:

Do not submit original copies. Any documents submitted to SCDHHS will not be returned.

You can return your documents using one of the methods below:

- **Upload online at:** apply.scdhhs.gov - **Email to:** 8888201204@fax.scdhhs.gov - **Fax to:** 888-820-1204

- **Mail to:** SCDHHS-Central Mail, PO Box 100101, Columbia, SC 29202-3101

- **In person:** To find your local eligibility office, visit the agency website at www.scdhhs.gov.

If you have any questions, please contact the Healthy Connections Member Services Center at (888) 549-0820 (TTY) (888) 842-3620. Thank you for your cooperation.