South Carolina Healthy Connections
PO Box 100101
Columbia, SC 29202
(888) 549-0820

Date:
BG#:
HH#:
Case Name:

South Carolina Medicaid Program
Annual TEFRA Review Form

This form is used to review your TEFRA Medicaid Coverage

You must return this form to us by:

- If you do not return this form, your TEFRA Medicaid will stop.
- If you do not return proof of your child's income and resources, the TEFRA Medicaid will stop.
- Please fill out EACH item on this form.
- If an item does not apply, write “does not apply.”
- If an answer to any question is none or 0, write “none.”

If you need help filling out this form, call your worker listed above.
Si necesita ayuda para llenar este formulario, puede llamar a su trabajador cuyo nombre aparece arriba.

What language do you use most? ☐ English ☐ Spanish ☐ Other (specify) _____

1. Fill out the following information about beneficiary.

Last Name	**First Name**			**Middle Initial**
Mailing Address (include Apartment / Lot Number)	**City**	**County**	**State**	**Zip Code**
Street Address (if different (include Apartment / Lot Number)	**City**	**County**	**State**	**Zip Code**
Child's Full Name at Birth		**Child's Mother Full Name at her Birth**		
Telephone Number **Phone # ( )** **Second Phone # ( )**	**County/State where child was born**		**FOR AGENCY USE** Date Received:	

2. Please fill out the following information about the child's parents or guardians.

Name:	**Relationship to Child:**	**Date of Birth:**	**Sex:** ☐ Female ☐ Male

Race:
☐ White ☐ African American ☐ Native American/American Indian ☐ Puerto Rican ☐ Refugee Entrant
☐ Hispanic ☐ Mexican ☐ Asian American/Oriental ☐ Cuban ☐ Other

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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Race:
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3. Does the TEFRA child work? ☐ **Yes** ☐ **No**
Is the TEFRA child self employed? ☐ Yes ☐ No If yes, you must send copies of the most recent income tax forms with all schedules.
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 with this application.

TEFRA Child's income from Employment	
Name of person employed	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐Monthly
Employer's Name	
Employer's Address	Name of Self-Employment Business and/or Partnership
Employer's Phone Number (including area code)	

4. Please list below ANY money received by the TEFRA child. If the answer is $0 or does not apply, write "none".
You must send proof of income received in the past 4 weeks.

Other Income	**Amount**	**Which family member gets this income?**	**How often is this income received?**
Child Support	$		
Social Security Income	$		
Veteran Benefits	$		
Cash Contributions	$		
Interest	$		
Other Income (*Please Explain*)	$		

5. Does anyone have any assets or resources like those listed below? ☐ Yes ☐ No You must send proof of the value of each.

Asset / Resource	Yes	No	Company name, address and phone #; Account Policy number; and/or description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand					$	$
Checking Account(s)					$	$
Savings Account(s)					$	$
Certificate(s) of Deposit					$	$
Annuities/Trusts/Stocks/ Bonds					$	$
Property (location/description)					$	$
Life/Burial insurance					$	$
Burial Contracts					$	$
Burial Plots					$	$
Vehicles (make, model, year)					$	$
Other (please be specific)					$	$

6. Has the TEFRA child added or dropped private health insurance or long-term coverage that covers medical expenses?

☐ Added ☐ Dropped

If added or dropped: Name if Insurance _____

If added, please send a copy of the insurance card (front and back). Do not include Medicare or Medicaid.

If dropped, please send a copy of the termination letter.

IMPORTANT

Did you remember to attach the information to complete your Annual review?

☐ Proof of your earnings ☐ Proof of your Income ☐ Proof of assest or resources

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 Medicaid Program. At times, the Department of Health and Human Services 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 Medicaid Card(s).
    a. I know that, in accordance with the federal rules governing the Medicaid 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 Medicaid 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 me and my family 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' Medicaid programs, and the TAN and food Stamp agency (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 31137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(l)], 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 Medicaid 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 Medicaid 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/custodial relatives want Medicaid coverage.
7. I understand that 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.
8. I know that I may request a hearing if I believe an error has been made in processing my application.

I have read the Rights and Responsibilties, or they have been read to me. *(If possible, both the Applicant and Authorized Representative should sign.) By signing, I state that I have read and agree to the rights and responsibilities stated on this application. I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.*

Applicant's Signature: _____ Date: _____

Authorized Representative's Signature: _____ Date: _____