South Dakota Department of Social Services

Strong Families - South Dakota's Foundation and Our Future

Application for Medicare Savings Programs

THINGS TO KNOW

Use this application to see what coverage you qualify for

- Medicaid can help pay for Medicare premiums as well as deductibles, copays, and coinsurance in some instances. These benefits are typically referred to as Medicare Savings Programs.
- There are four types of Medicare Savings Programs
    - Qualified Medicare Beneficiaries (QMB)
    - Special Low-Income Medicare Beneficiaries (SLMB)
    - Qualified Individuals (QI)
    - Qualified Disabled Working Individuals (QDWI)
- The QMB program covers both Medicare premiums and deductibles, copays, and coinsurance. The SLMB, QI, and QDWI programs only cover Medicare premiums.

Who can use this application?

- Single individuals who are entitled to or receiving Medicare benefits.
- Married individuals or couples who are entitled to or receiving Medicare benefits.

Learn more online

You can learn more about eligibility for Medical Assistance programs at **https://dss.sd.gov/medicaid/Eligibility/default.aspx**

What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Resource information (for example, bank statements, insurance contracts, and other contractual agreements)

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

We'll keep all the information you provide private and secure, as required by law. To view our Notice of Privacy Practices, go to dss.sd.gov/keyresources/hipaa/

What happens next?

Send your complete, signed application to your local DSS office. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you. Filling out this application doesn't mean you have to accept health coverage.

Get help with this application

- **Online:** dss.sd.gov
- **Phone:** Call your local office dss.sd.gov/findyourlocaloffice/
- **In person:** Visit your local office dss.sd.gov/findyourlocaloffice/

Language Assistance

1. **Español (Spanish) -** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-999-5612 (TTY: 711).
2. **Deutsch (German) -** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-999-5612 (TTY: 711).
3. **繁體中文 (Chinese) -** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-999-5612（TTY：711）
4. **ကညီ (Karen) -** ဟ်သူၣ်ဟ်သး–နမ့ၢ်ကတိၤကညီကျိာ်အယိ,နမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤလၢတလၢာ်ဘူၣ်လၢာ်စ့ၢ်နီတမံၤဘၣ်သ့န့ၣ်လီၤ.ကိး 1-877-999-5612 (TTY: 711).
5. **Tiếng Việt (Vietnamese) -** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-999-5612 (TTY: 711).
6. **नेपाली (Nepali) -** ध्यान दनहु ोस:ृ तपाइले नेपाल बोल्नहन्छ भन तपाइको ननम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनहु ोसर ृ 1-877-999-5612 (टटवाइ: 711)
7. **Srpsko-hrvatski (Serbo-Croatian) -** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-999-5612 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
8. **አማርኛ (Amharic) -** ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-999-5612 (መስማት ለተሳናቸው: 711).
9. Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-877-999-5612 (TTY: 711).
10. **Tagalog (Tagalog – Filipino) -** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-999-5612 (TTY: 711).
11. **한국어 (Korean) -** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-999-5612 (TTY: 711)번으로 전화해 주십시오.
12. **Русский (Russian) -** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-999-5612 (телетайп: 711).
13. **Cushite Oroomiffa (Oromo) -** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-999-5612 (TTY: 711).
14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 1-877-999-5612 (TTY: 711).
15. **Français (French) -** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-999-5612 (ATS : 711).

1. Information about You and Your Spouse (If Applicable)

FIRST NAME | MI | LAST NAME | DATE OF BIRTH

GENDER
☐ MALE ☐ FEMALE

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SOCIAL SECURITY NUMBER

IF YOU DON'T HAVE A SOCIAL SECURITY NUMBER, HAVE YOU APPLIED FOR ONE?
☐ YES ☐ NO

ARE YOU A VETERAN OR THE SPOUSE OF A VETERAN?
☐ YES ☐ NO

DO YOU HAVE A PHYSICAL, MENTAL, OR EMOTIONAL HEALTH CONDITION THAT CAUSES LIMITATIONS IN ACTIVITIES (LIKE BATHING, DRESSING, DAILY CHORES, ETC.)?
☐ YES ☐ NO

ARE YOU A U.S. CITIZEN OR NATIONAL?
☐ YES ☐ NO

IF NO, WHAT IS YOUR IMMIGRATION STATUS?

IMMIGRATION DOCUMENT TYPE | ALIEN ID NUMBER | PASSPORT NUMBER

DATE YOU ENTERED THE U.S. (MM/DD/YYYY)

DO YOU HAVE A SPONSOR?
☐ YES ☐ NO

IF YES, SPONSOR NAME

RACE (OPTIONAL)
☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER

HISPANIC OR LATINO? (OPTIONAL)
☐ YES ☐ NO

IF NATIVE AMERICAN OR ALASKAN NATIVE, HAVE YOU RECEIVED OR ARE YOU ELIGIBLE TO RECEIVE SERVICES FROM INDIAN HEALTH SERVICES (IHS), URBAN INDIAN HEALTH OR OTHER TRIBAL HEALTHCARE SERVICES?
☐ YES ☐ NO

DO YOU PLAN TO FILE A TAX RETURN?
☐ YES ☐ NO

IF YES, DO YOU PLAN TO FILE JOINTLY WITH A SPOUSE?
☐ YES ☐ NO

LIST ANY PERSON(S) YOU PLAN TO CLAIM AS A DEPENDENT ON YOUR TAX RETURN.

SPOUSE FIRST NAME | MI | SPOUSE LAST NAME | DATE OF BIRTH

GENDER
☐ MALE ☐ FEMALE

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SOCIAL SECURITY NUMBER

IF YOU DON'T HAVE A SOCIAL SECURITY NUMBER, HAVE YOU APPLIED FOR ONE?
☐ YES ☐ NO

IS YOUR SPOUSE A VETERAN OR THE SPOUSE OF A VETERAN?
☐ YES ☐ NO

DO YOUR SPOUSE HAVE A PHYSICAL, MENTAL, OR EMOTIONAL HEALTH CONDITION THAT CAUSES LIMITATIONS IN ACTIVITIES (LIKE BATHING, DRESSING, DAILY CHORES, ETC.)?
☐ YES ☐ NO

ARE YOU A U.S. CITIZEN OR NATIONAL?
☐ YES ☐ NO

IF NO, WHAT IS YOUR IMMIGRATION STATUS?

IMMIGRATION DOCUMENT TYPE | ALIEN ID NUMBER | PASSPORT NUMBER

DATE YOU ENTERED THE U.S. (MM/DD/YYYY)

DO YOU HAVE A SPONSOR?
☐ YES ☐ NO

IF YES, SPONSOR NAME

RACE (OPTIONAL)
☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER

HISPANIC OR LATINO? (OPTIONAL)
☐ YES ☐ NO

IF NATIVE AMERICAN OR ALASKAN NATIVE, HAVE YOU RECEIVED OR ARE YOU ELIGIBLE TO RECEIVE SERVICES FROM INDIAN HEALTH SERVICES (IHS), URBAN INDIAN HEALTH OR OTHER TRIBAL HEALTHCARE SERVICES?
☐ YES ☐ NO

2. Dependents

DO YOU OR YOUR SPOUSE HAVE ANY CHILDREN OR OTHER DEPENDENTS LIVING WITH YOU?

☐ YES ☐ NO

NAME OF DEPENDENT	RELATIONSHIP

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE
US CITIZEN? ☐ YES ☐ NO	RACE ☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER	

NAME OF DEPENDENT	RELATIONSHIP

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE
US CITIZEN? ☐ YES ☐ NO	RACE ☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER	

* If you have more than two dependents, please include the same information for each on a separate piece of paper.

3. Contact Information

RESIDENTIAL ADDRESS			
CITY	STATE	COUNTY	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)			
CITY	STATE	COUNTY	ZIP CODE
PHONE NUMBER	E-MAIL ADDRESS		

4. Authorized Representative

DO YOU WISH TO AUTHROIZE A PERSON TO ACT ON YOUR BEHALF AS AN AUTHORIZED REPSENTATIVE? IF YES, PLEASE COMPLETE THIS SECTION AND THE FORM IN SECTION 17.

☐ YES ☐ NO

IF YES, NAME	RELATIONSHIP OR ORGANIZATION	
MAILING ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER	E-MAIL ADDRESS	

5. Medical Assistance Start Date

WHO ARE YOU APPLYING FOR?

☐ SELF ☐ SPOUSE

DO YOU WANT ASSISTANCE PAYING FOR PREMIUMS OR MEDICAL BILLS IN THE PAST THREE (3) MONTHS?*

☐ YES ☐ NO

IF YES, HOW MANY MONTHS IN THE PAST DO YOU NEED ASSISTANCE?

☐ ONE ☐ TWO ☐ THREE

*Assistance cannot begin prior to the date you become entitled to Medicare benefits.

6. Medicare Information

DO YOU OR YOUR SPOUSE HAVE MEDICARE? IF YES, PLEASE COMPLETE BELOW

☐ YES ☐ NO

	YOU	**SPOUSE**
PLAN TYPE	☐ PART A ☐ PART B ☐ PART C ☐ PART D	☐ PART A ☐ PART B ☐ PART C ☐ PART D
PART D PLAN NAME (IF APPLICABLE)		
EFFECTIVE DATE		
MEDICARE ID NUMBER		

7. Income from Sources Other Than Employment

DO YOU OR YOUR SPOUSE RECEIVE MONEY FROM SOURCES OTHER THAN WORK?* THESE INCLUDE THE FOLLOWING:

- SOCIAL SECURITY
- SUPPLEMENTAL SECURITY INCOME (SSI)
- RETIREMENT ACCOUNTS
- PENSION FUNDS
- SPOUSAL SUPPORT
- WORKER'S COMPENSATION
- UNEMPLOYMENT
- VETERANS' BENEFITS
- RENTAL INCOME
- ANNUITIES
- TRUSTS
- ROYALTIES
- OTHER SOURCES

☐ YES ☐ NO

NAME	TYPE OF INCOME	AMOUNT	HOW OFTEN
		$	
		$	
		$	
		$	

* You must provide verification of any income listed above. This may include award letters, benefit statements, rental agreements, etc.

8. Employment Income

DO YOU OR YOUR SPOUSE RECEIVE INCOME FROM A JOB?*

☐ YES ☐ NO

NAME OF PERSON WORKING	EMPLOYER NAME

IS THIS JOB TEMPORARY?	HAS THIS JOB ENDED?	IF YES, END DATE (MM/DD/YYYY)
☐ YES ☐ NO	☐ YES ☐ NO	

AMOUNT OF INCOME BEFORE TAXES	HOW OFTEN?

* You must provide a copy of paystubs covering the most recent month with your application

9. Self-Employment

ARE YOU OR YOUR SPOUSE SELF-EMPLOYED?*

☐ YES ☐ NO

NAME OF SELF-EMPLOYED PERSON	BUSINESS NAME
MONTHLY INCOME	MONTHLY EXPENSES

* You must provide a copy of your most recent tax return with your application

10. Vehicles

DO YOU OR YOUR SPOUSE HAVE ANY CARS, TRUCKS, BOATS, OR OTHER RECREATIONAL VEHICLES?

☐ YES ☐ NO

OWNER NAME(S)	MAKE/MODEL	YEAR	VALUE	AMOUNT OWED
			$	$
			$	$
			$	$
			$	$

IF MORE THAN ONE VEHICLE IS LISTED ABOVE, WHICH DO YOU USE AS YOUR PRIMARY METHOD OF TRANSPORTATION?

11. Home Property

DO YOU OR YOUR SPOUSE OWN A HOME (INCLUDING A MOBILE HOME)?

☐ YES ☐ NO

OWNER NAME(S)	VALUE	AMOUNT OWED

ADDRESS	CITY	STATE	ZIP

12. Resources

DO YOU OR YOUR SPOUSE HAVE ANY RESOURCES? EXAMPLES OF RESOURCES INCLUDE THE FOLLOWING:

- CASH
- CHECKING/SAVINGS ACCOUNTS *(INCLUDING JOINT ACCOUNTS)*
- CERTIFICATES OF DEPOSIT
- DIRECT EXPRESS/PAYROLL CARDS
- SAFETY DEPOSIT BOXES
- RETIREMENT ACCOUNTS
- STOCKS/BONDS/MUTUAL FUNDS
- DIRECT EXPRESS/PAYROLL CARDS
- GOVERNMENT BONDS
- ANNUITIES
- BURIAL PLOTS
- FUNERAL PLANS
- TRUSTS
- LIFE ESTATES
- PROPERTY RIGHTS
- OTHER SOURCES

☐ YES ☐ NO

TYPE OF RESOURCE	ACCOUNT NUMBER	VALUE	NAME OF BANK, FINANCIAL INSTITUTION, ETC.
		$	
		$	
		$	
		$	
		$	

* You must provide the last three (3) months of statements for each account listed with your application

13. Life Insurance

DO YOU OR YOUR SPOUSE OWN ANY LIFE INSURANCE POLICIES?

☐ YES ☐ NO

NAME OF INSURED PERSON (FIRST NAME, MI, LAST NAME)	NAME OF POLICY OWNER	
POLICY START DATE	FACE VALUE	CASH VALUE
INSURANCE COMPANY NAME	POLICY NUMBER	

ADDRESS	CITY	STATE	ZIP

NAME OF INSURED PERSON (FIRST NAME, MI, LAST NAME)	NAME OF POLICY OWNER	
POLICY START DATE	FACE VALUE	CASH VALUE
INSURANCE COMPANY NAME	POLICY NUMBER	

ADDRESS	CITY	STATE	ZIP

14. Private Health Insurance

ARE YOU OR YOUR SPOUSE HAVE PRIVATE HEALTH INSURANCE OR MEDICARE SUPPLEMENTAL INSURANCE?

☐ YES ☐ NO

NAME OF INSURED PERSON	NAME OF POLICY HOLDER	
INSURANCE COMPANY NAME	POLICY NUMBER	POLICY START DATE

COMPANY ADDRESS	CITY	STATE	ZIP

HOW MUCH IS THE PREMIUM?	HOW OFTEN IS THE PREMIUM PAID? ☐ MONTHLY ☐ QUARTERLY ☐ YEARLY	TYPE OF COVERAGE (MEDIGAP, RX, ETC)

DO YOU GET THIS INSURANCE THROUGH AN EMPLOYER? ☐ YES ☐ NO	IF YES, LIST EMPLOYER'S NAME

15. Statement of Understanding

ASSIGNMENT OF MEDICAL SUPPORT AND INSURANCE PROCEEDS
AN APPLICATION FOR AND ACCEPTANCE OF MEDICAL ASSISTANCE PAID FROM THE DEPARTMENT OF SOCIAL SERVICES SHALL OPERATE AS AN ASSIGNMENT AND SUBROGATION OF ANY RIGHTS TO MEDICAL SUPPORT, INSURANCE PROCEEDS, OR BOTH THAT THE APPLICANT OR RECIPIENT MAY HAVE. ANY RIGHTS OR AMOUNTS SO ASSIGNED OR SUBROGATED SHALL BE APPLIED AGAINST THE COST OF THE APPLICANT'S OR RECIPIENT'S CARE.

DISCLOSURE OF ANNUITIES AND STATE TO BE NAMED AS REMAINDER BENEFICIARY
PUBLIC LAW NO. 109-171 DEFICIT REDUCTION ACT OF 2005 SECTION 6012 REQUIRES INDIVIDUALS APPLYING FOR LONG-TERM CARE MEDICAL ASSISTANCE AND AN INDIVIDUAL WHOSE ELIGIBILITY IS BEING REVIEWED FOR PURPOSES OF DETERMINING WHETHER THE INDIVIDUAL CONTINUES TO BE ELIGIBLE FOR LONG-TERM CARE ASSISTANCE TO DISCLOSE THE DESCRIPTION OF ANY INTEREST THE INDIVIDUAL OR THE INDIVIDUAL'S SPOUSE HAS IN AN ANNUITY OR SIMILAR FINANCIAL INSTRUMENT. FAILURE TO DISCLOSE THIS INFORMATION RESULTS IN INELIGIBILITY FOR ASSISTANCE. IN ADDITION, A RECIPIENT OF LONG TERM CARE ASSISTANCE MUST NAME THE DEPARTMENT AS A PREFERRED REMAINED BENEFICIARY OF ANY INTEREST THE INDIVIDUAL OR INDIVIDUAL'S SPOUSE HAS IN AN ANNUITY OR SIMILAR FINANCIAL INSTRUMENT PURCHASED AND OWNED AFTER FEBRUARY 7, 2006.

PRIVACY ACT STATEMENT
FEDERAL AND STATE LAW AND REGULATIONS LIMIT THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION CONCERNING APPLICANTS AND RECIPIENTS OF ECONOMIC AND MEDICAL ASSISTANCE PROGRAMS TO PURPOSES DIRECTLY RELATED TO THE ADMINISTRATION OF THOSE PROGRAMS. WHEN YOU APPLY FOR ASSISTANCE, YOU WILL BE ASKED TO PROVIDE YOUR SOCIAL SECURITY NUMBER (SSN) ON THE APPLICATION FORM. TITLE 42 OF THE CODE OF FEDERAL REGULATIONS PART 435.910(A), REQUIRES THE FURNISHING OF A SSN AS A CONDITION OF ELIGIBILITY FOR MEDICAID. THE DEPARTMENT USES YOUR NUMBER IN ITS COMPUTER PROCESSING OF ELIGIBILITY DETERMINATION, WELFARE FRAUD INVESTIGATION AND AUDITS. SSNS ARE ALSO USED TO VERIFY INCOME INFORMATION THROUGH AGENCIES SUCH AS THE IRS, DEPARTMENT OF LABOR, AND SOCIAL SECURITY ADMINISTRATION, ETC., TO PREVENT A PERSON OR FAMILY FROM RECEIVING DUPLICATE BENEFITS UNDER ANY PROGRAM, TO MAKE MASS CHANGES IN BENEFITS EASIER TO IMPLEMENT AND TO DETERMINE THE ACCURACY AND RELIABILITY OF INFORMATION GIVEN TO THE DEPARTMENT BY APPLICANT FOR AND RECIPIENTS OF ASSISTANCE.

VERIFICATIONS
INFORMATION YOU GIVE TO ANSWER THE QUESTIONS ON THIS FORM, AND INFORMATION OBTAINED BY THE DEPARTMENT TO VERIFY YOUR ANSWERS WILL BE USED TO DETERMINE YOUR ELIGIBILITY AND LEVEL OF BENEFITS. YOUR BENEFITS MAY CHANGE FROM MONTH TO MONTH, OR BE STOPPED, BASED ON THIS INFORMATION.

FEDERAL AND STATE OFFICIALS WILL VERIFY INFORMATION GIVEN ON THIS FORM TO DETERMINE IF IT IS CORRECT. A DEPARTMENT REPRESENTATIVE MAY CONTACT YOU OR MAY CONTACT OTHER PEOPLE IN ORDER TO VERIFY YOUR ELIGIBILITY FOR ASSISTANCE. INFORMATION GIVEN WILL ALSO BE VERIFIED BY COMPUTER CROSS-MATCHING WITH OTHER AGENCIES AND PRIVATE SECTORS. WHEN STATE AND FEDERAL PERSONNEL VERIFY THE INFORMATION ON THIS APPLICATION, IF WHAT IS REPORTED IS FOUND TO BE INCORRECT YOUR MEDICAL CASE MAY BE DENIED OR TERMINATED AND YOU MAY BE SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION

MEDICAID ESTATE RECOVERY PROGRAM
UNDER FEDERAL AND STATE LAW, THE DEPARTMENT OF SOCIAL SERVICES IS AUTHORIZED TO MAKE RECOVERY FROM THE ESTATES OF DECEASED MEDICAL ASSISTANCE RECIPIENTS WHO WERE PERMANENTLY INSTITUTIONALIZED OR WHO WERE AT LEAST 55 YEARS OF AGE AND FOR WHOM THE DEPARTMENT MADE A PAYMENT FOR NURSING FACILITY SERVICES, INTERMEDIATE CARE FACILITY SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, OTHER MEDICAL INSTITUTIONAL SERVICES, HOME AND COMMUNITY BASED SERVICES, HOSPITAL SERVICES, AND PRESCRIPTION DRUG SERVICES. THE DEPARTMENT OF SOCIAL SERVICES IS AUTHORIZED TO RECOVER THE DEBT OF A MEDICAL ASSISTANCE RECIPIENT FROM THE ESTATE OF A SURVIVING SPOUSE. IF A SURVIVING SPOUSE WISHES TO LIMIT THE AMOUNT OF THE SURVIVING SPOUSE'S ESTATE THAT WILL BE LIABLE FOR RECOVERY FOR THE AMOUNT OF MEDICAL ASSISTANCE PAID ON BEHALF OF THE RECIPIENT, THE SURVIVING SPOUSE MUST FILE A PETITION WITHIN SIX MONTHS OF THE DEATH OF THE MEDICAL ASSISTANCE RECIPIENT. THE PETITION WILL DETERMINE THE AMOUNT OF THE SURVIVING SPOUSE'S ESTATE FROM WHICH RECOVERY MAY BE CLAIMED FOR MEDICAID EXPENDED ON BEHALF OF THE RECIPIENT. THE PETITION MUST BE FILED ON THE DEPARTMENT'S FORM.

UNDER FEDERAL AND STATE LAW, THE DEPARTMENT OF SOCIAL SERVICES MAY IMPOSE A MEDICAL ASSISTANCE LIEN AGAINST REAL PROPERTY OWNED BY A RECIPIENT WHO HAS RECEIVED A BENEFIT FROM THE DEPARTMENT OF SOCIAL SERVICES FOR THE SERVICES OF A NURSING FACILITY, AN INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, OR OTHER MEDICAL INSTITUTION. THE DEPARTMENT OF SOCIAL SERVICES WILL ISSUE A SEPARATE NOTICE WHEN THE DEPARTMENT DECIDES TO IMPOSE A LIEN. THE NOTICE WILL DESCRIBE THE AMOUNT OF THE LIEN AND THE REAL PROPERTY TO WHICH THE LIEN IS TO ATTACH. UNDER STATE LAW, THE DEPARTMENT OF SOCIAL SERVICES IS AUTHORIZED TO RECOVER ANY FUNDS OF THE RESIDENT KEPT OR MAINTAINED BY THE NURSING HOME OR OTHER FACILITY IF THE RESIDENT WAS RECEIVING MEDICAL ASSISTANCE FROM THE DEPARTMENT AT THE TIME OF DEATH. INFORMATION IN REGARD TO THE ESTATE RECOVERY PROGRAM, CAN BE LOCATED AT HTTP://DSS.SD.GOV/KEYRESOURCES/BENEFITFRAUD/ESTATE.ASPX

NOTICE OF NONDISCRIMINATION
AS A RECIPIENT OF FEDERAL FINANCIAL ASSISTANCE AND A STATE OR LOCAL GOVERNMENTAL AGENCY, THE DEPARTMENT OF SOCIAL SERVICES DOES NOT EXCLUDE, DENY BENEFITS TO, OR OTHERWISE DISCRIMINATE AGAINST ANY PERSON ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN, OR ON THE BASIS OF DISABILITY OR AGE IN ADMISSION OR ACCESS TO, OR TREATMENT OR EMPLOYMENT IN, ITS PROGRAMS, ACTIVITIES, OR SERVICES, WHETHER CARRIED OUT BY THE DEPARTMENT OF SOCIAL SERVICES DIRECTLY OR THROUGH A CONTRACTOR OR ANY OTHER ENTITY WITH WHICH THE DEPARTMENT OF SOCIAL SERVICES ARRANGES TO CARRY OUT ITS PROGRAMS AND ACTIVITIES; OR ON THE BASIS OF ACTUAL OR PERCEIVED RACE, COLOR, RELIGION, NATIONAL ORIGIN, SEX, GENDER IDENTITY, SEXUAL ORIENTATION OR DISABILITY IN ADMISSION OR ACCESS TO, OR TREATMENT OR EMPLOYMENT IN, ITS PROGRAMS, ACTIVITIES, OR SERVICES WHEN CARRIED OUT BY THE DEPARTMENT OF SOCIAL SERVICES DIRECTLY OR WHEN CARRIED OUT BY SUB-RECIPIENTS OF GRANTS ISSUED BY THE UNITED STATES DEPARTMENT OF JUSTICE, OFFICE ON VIOLENCE AGAINST WOMEN.

THE DEPARTMENT OF SOCIAL SERVICES PROVIDES FREE AIDS AND SERVICES TO PEOPLE WITH DISABILITIES TO COMMUNICATE EFFECTIVELY SUCH AS QUALIFIED SIGN LANGUAGE INTERPRETERS AND WRITTEN INFORMATION IN OTHER FORMATS (E.G. LARGE PRINT, AUDIO, ACCESSIBLE ELECTRONIC FORMATS, OTHER FORMATS) AND PROVIDES 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, CONTACT YOUR LOCAL DSS OFFICE.

IF YOU BELIEVE THAT DSS 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 DISCRIMINATION COMPLAINT OR GRIEVANCE WITH: DISCRIMINATION COORDINATOR, DIRECTOR OF DSS DIVISION OF LEGAL SERVICES, 700 GOVERNORS DRIVE, PIERRE, SD 57501. PHONE: (605) 773-3305, FAX: (605) 773-7223, DSSINFO@STATE.SD.US. YOU CAN FILE A DISCRIMINATION COMPLAINT OR GRIEVANCE IN PERSON OR BY MAIL, FAX, OR EMAIL. IF YOU NEED HELP FILING A DISCRIMINATION COMPLAINT OR GRIEVANCE, THE DISCRIMINATION COORDINATOR, DIRECTOR OF DSS DIVISION OF LEGAL SERVICES IS 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 1-800-368-1019, 800-537-7697 (TDD) COMPLAINT FORMS ARE AVAILABLE AT HTTP://WWW.HHS.GOV/OCR/OFFICE/FILE/INDEX.HTML.

THIS STATEMENT IS IN ACCORDANCE WITH THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE II OF THE AMERICANS WITH DISABILITIES ACT OF 1990, THE AGE DISCRIMINATION ACT OF 1975, AND THE REGULATIONS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ISSUED PURSUANT TO THESE STATUTES AT TITLE 45 CODE OF FEDERAL REGULATIONS (CFR) PARTS 80, 84, AND 91, AND 28 CFR PART 35, THE OMNIBUS CRIME CONTROL AND SAFE STREETS ACT OF 1968, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, EQUAL TREATMENT FOR FAITH-BASED RELIGIONS AT 28 CFR PART 38, THE VIOLENCE AGAINST WOMEN REAUTHORIZATION ACT OF 2013, AND SECTION 1557 OF THE AFFORDABLE CARE ACT.

16. Would you like to Register to Vote?

Applying to register or declining to register to vote will not affect the amount of assistance that you are provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES ☐ NO

If you do not check either box, you will be considered to have decided NOT to register to vote at this time.

(Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.)

If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

17. Authorization to Release Information

I, ______________________________, authorize the Department of Social Services (DSS), Division of Economic Assistance (EA) to disclose my protected health information to the following individual/facility. My date of birth is: ____________________

Individual/Facility and Name of Facility Person to Receive Information: ____
Address: ____
Phone Number: _______________
Fax Number: _______________

This authorization is for the time period from: __________ to __________. If left blank, this authorization shall expire 1 year from the date of execution.

I allow DSS-EA to release only the following checked information to the above strategy: (check all that apply)
☐ Copy of Application/Renewal Form Dated: Month(s) __________ Year(s) __________ ☐ Address on File
☐ Copy of Notices from DSS-EA Relating to Application/Renewal Form Dated: Month(s) __________ Year(s) __________
☐ Copy of Verification Checklist Form (EA-300) Dated: Month(s) __________ Year(s) __________

Purpose of this disclosure:
I understand if this information is released to a third party, the information may be released by the person or entity that receives that information may no longer be protected by federal or other applicable privacy regulations.

I understand that I may revoke this authorization, except to the extent that staff has already taken action upon it, by sending written notice to the Department of Social Services, Division of Economic Assistance, 700 Governors Drive, Pierre, SD 57501.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify.

Signature	Printed Name	Date
Address of Individual Signing	City/State/Zip	Phone

If signed by someone other than Applicant/Recipient indicate relationship (check appropriate box)

☐ Spouse ☐ Parent (if for child under 18) ☐ Power of Attorney ☐ Legal Guardian

18. Sign and Authorize Application (Required)

I UNDERSTAND THAT ANY FALSE STATEMENTS WHICH I MAY MAKE AND ANY FAILURE ON MY PART TO REPORT ANY CHANCE IN CIRCUMSTANCE WHICH WOULD AFFECT MY ELIGIBILITY FOR PAYMENT FROM PROGRAMS ADMINISTERED BY THE SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES CONSTITUTES A CRIME AND THAT I COULD BE PROSECUTED UNDER SOUTH DAKOTA CRIMINAL LAWS.

I AGREE TO PROVIDE INFORMATION UPON REQUEST FROM THE DEPARTMENT OF SOCIAL SERVICES CONCERNING ANY ASSET OR ESTATE WHICH MAY BE SUBJECT TO RECOVERY, ESTATE RECOVERY, OR MEDICAL ASSISTANCE LIENS BY THE STATE OF SOUTH DAKOTA.

I HEREBY AUTHORIZE ANY PERSON, AGENCY, OR INSTITUTIONS TO SUPPLY INFORMATION REQUESTED BY THE DEPARTMENT OF SOCIAL SERVICES CONCERNING ME OR MY FAMILY AND ALLOW INSPECTION AND REPRODUCTION OF THE RECORDS IN HIS OR THEIR POSSESSION PERTAINING TO ME OR MY FAMILY BY ANY DULY AUTHORIZED REPRESENTATIVE OF THE DEPARTMENT. I FURTHER AUTHORIZE THE DEPARTMENT TO RELEASE SUCH INFORMATION TO PROVIDERS OR COOPERATING STATE OR FEDERAL AGENCIES.

THIS AUTHORIZATION IS GIVEN ONLY IN CONNECTION WITH ITS USE BY THE DEPARTMENT IN THE ADMINISTRATION OF ITS PROGRAMS AND FOR NO OTHER PURPOSE. IT SHALL CONTINUE IN EFFECT UNTIL SUCH TIME AS I STATE IN WRITING THAT IT IS NO LONGER VALID.

I THEREWITH RELEASE ANY PERSON, AGENCY OR INSTITUTION FROM ANY AND ALL LIABILITY TO ME OR MY FAMILY FOR SUPPLYING SUCH INFORMATION.

APPLICANT	SPOUSE
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME

IF YOU ARE A PARENT, GUARDIAN, AUTHORIZED REPRESENTATIVE, COURT APPOINTED ADMINISTRATOR, EXECUTOR, OR HAVE POWER OF ATTORNEY FOR THIS PERSON, SIGN BELOW:

SIGN HERE (MUST PROVIDE PROOF)

SIGN HERE IF YOU ARE A WITNESS (ONLY NEEDED IF ANYONE ABOVE SIGNED WITH AN “X” OR OTHER MARK)

PRINTED NAME OF WITNESS