

# Children and Family Medical Assistance Supplemental Application



## Get help with this form

If you need help completing this form or submitting it to the local Department of Social Services office, please call your local Department of Social Services office and ask for help. A list of local offices can be found at <http://dss.sd.gov/offices/>.

Please print in capital letters using black or dark blue ink only.  
Fill in the circles (○) like this → ●.

## STEP 1: Tell us about yourself.

(We need information about the individual that is the contact person for your case.)

1. First name		Middle name		Last name		Suffix	
2. Home address (Leave blank if you don't have one.)		3. Apartment or suite number					
4. City		5. State	6. ZIP code		7. County, parish, or township		
8. Mailing address (if different from home address)		9. Apartment or suite number					
10. City		11. State	12. ZIP code		13. County, parish, or township		
14. Daytime phone number ( ) -			15. Evening phone number ( ) -				
16. Do you want to get information about this application by email? ..... <input type="radio"/> Yes <input type="radio"/> No							
Email address:							
17. What's your preferred spoken language? What's your preferred written language?							

## STEP 2: Tell us about the household member requesting medical assistance.

### Who do you need to include on this application?

Complete pages 2 and 3 for every household member requesting a medical assistance determination. If you are requesting assistance for more than one person, make copies of pages 2 and 3 or provide the information requested on these pages on a separate piece of paper. Completion of the race and ethnicity section of the application is optional.

# STEP 2: Tell us about the household member requesting medical assistance.

Complete Step 2 for any new household member who needs a Medicaid determination.

1. First name		Middle name	Last name	Suffix
<input type="text"/>				
2. Relationship to Contact Person?		3. Are you married? <input type="radio"/> Yes <input type="radio"/> No		4. Date of birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>		<input type="text"/>		5. Sex <input type="radio"/> Male <input type="radio"/> Female
6. Social Security Number (SSN) <input type="text"/> - <input type="text"/> - <input type="text"/>				
<p><b>We need this if you want health coverage and have an SSN.</b> Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check eligibility for coverage and, if you apply, for help with coverage costs. For help getting an SSN, call Social Security at 1-800-772-1213, or visit <a href="https://socialsecurity.gov">socialsecurity.gov</a>. TTY users should call 1-800-325-0778.</p>				
7. Does new member plan to file a federal income tax return NEXT YEAR? <i>You can still apply for coverage even if you don't file a federal income tax return.</i>				
<input type="radio"/> <b>YES. If yes</b> , please answer questions a-c. <input type="radio"/> <b>NO. If no</b> , skip to question c.				
a. Will new member file jointly with a spouse? ..... <input type="radio"/> Yes <input type="radio"/> No				
If yes, write name of spouse: <input type="text"/>				
b. Will new member claim any dependents on your tax return?..... <input type="radio"/> Yes <input type="radio"/> No				
If yes, list name(s) of dependents: <input type="text"/>				
c. Will new member be claimed as a dependent on someone's tax return?..... <input type="radio"/> Yes <input type="radio"/> No				
If yes, please list the name of the tax filer: <input type="text"/>			How are you related to the tax filer? <input type="text"/>	
8. Is new member pregnant? Yes <input type="radio"/> No <input type="radio"/> a. If yes, how many babies are expected during this pregnancy? Due date: <input type="text"/>				
9. Does new member need health coverage? <i>Even if you have coverage, there might be a program with better coverage or lower costs.</i>				
<input type="radio"/> <b>YES. If yes</b> , answer all the questions below. <span style="color: orange;">⬇</span> <input type="radio"/> <b>NO. If no</b> , SKIP to the income questions on page 3. Leave the rest of this page blank. <span style="color: orange;">➡</span>				
10. Does new member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?..... <input type="radio"/> Yes <input type="radio"/> No				
11. Is new member a U.S. citizen or U.S. national? ..... <input type="radio"/> Yes <input type="radio"/> No				
12. Is new member a naturalized or derived citizen? <i>(This usually means you were born outside the U.S.)</i>				
<input type="radio"/> <b>YES. If yes</b> , complete a and b. <input type="radio"/> <b>NO. If no</b> , continue to question 13.				
a. Alien number: <input type="text"/>			b. Certificate number: <input type="text"/>	
After you complete a and b, SKIP to question 14.				
13. If new member isn't a U.S. citizen or U.S. national, do they have eligible immigration status? <input type="radio"/> <b>YES</b> . Enter document type and ID number. <i>See instructions.</i>				
Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Alien or I-94 number <input type="text"/>		Card number or passport number <input type="text"/>		
SEVIS ID or expiration date (optional) <input type="text"/>		Other (category code or country of issuance) <input type="text"/>		
a. Has new member lived in the U.S. since 1996? ..... <input type="radio"/> Yes <input type="radio"/> No				
b. Is new member, or new member's spouse or parent, a veteran or an active-duty member of the U.S. military? ..... <input type="radio"/> Yes <input type="radio"/> No				
14. Does new member want help paying for medical bills from the last 3 months? ..... <input type="radio"/> Yes <input type="radio"/> No				
15. Does new member live with at least one child under the age of 19, and is new member the main person taking care of this child? <i>(Select "yes" if you or your spouse takes care of this child.)</i> ..... <input type="radio"/> Yes <input type="radio"/> No				
16. Tell us the names and relationships of any children under 19 that live with new member in your household: <input type="text"/>				
17. Is new member a full-time student?..... <input type="radio"/> Yes <input type="radio"/> No			18. Was new member in foster care at age 18 or older? ..... <input type="radio"/> Yes <input type="radio"/> No	
<b>Optional:</b> <span style="font-size: small;">(Fill in all that apply.)</span>				
19. If Hispanic/Latino, ethnicity: <input type="radio"/> Mexican <input type="radio"/> Mexican American <input type="radio"/> Chicano/a <input type="radio"/> Puerto Rican <input type="radio"/> Cuban <input type="radio"/> Other _____				
20. Race: <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Asian Indian <input type="radio"/> Chinese <input type="radio"/> Vietnamese <input type="radio"/> Other Asian <input type="radio"/> Native Hawaiian <input type="radio"/> Guamanian or Chamorro <input type="radio"/> Samoan <input type="radio"/> Other Pacific Islander <input type="radio"/> Other _____				

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# STEP 2: PERSON 1 (Continue with new member.)

## Current job & income information

- Employed:** If new member is currently employed, tell us about their income. Start with question 21.
  **Not employed:** Skip to question 31.
  **Self-employed:** Skip to question 30.

### Current job 1:

21. Employer name

a. Employer address

b. City	c. State	d. ZIP code	22. Employer phone number
			( ) -

23. Wages/tips (before taxes)  Hourly  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly

\$

24. Average hours worked each WEEK

### Current job 2: (If new member has additional jobs and need more space, attach another sheet of paper.)

25. Employer name

a. Employer address

b. City	c. State	d. ZIP code	26. Employer phone number
			( ) -

27. Wages/tips (before taxes)  Hourly  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly

\$

28. Average hours worked each WEEK

29. In the past year, did new member:  Change jobs  Stop working  Start working fewer hours  None of these

### 30. If new member is self-employed, answer a and b:

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? See *instructions*. \$

31. **Other income new member received this month:** Fill in all that apply, and give the amount and how often you get it.  Fill in here if none. **NOTE:** You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

<input type="radio"/> Unemployment	\$	How often?	<input type="radio"/> Alimony received	\$	How often?
<input type="radio"/> Pension	\$	How often?	<input type="radio"/> Net farming/fishing	\$	How often?
<input type="radio"/> Social Security	\$	How often?	<input type="radio"/> Net rental/royalty	\$	How often?
<input type="radio"/> Retirement accounts	\$	How often?	<input type="radio"/> Other income	\$	How often?
			Type:		

32. **Deductions:** Fill in all that apply, and give the amount and how often new member pays it. If new member pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include child support that new member pays, or a cost already considered in your answer to net self-employment (question 30b).

<input type="radio"/> Alimony paid	\$	How often?	<input type="radio"/> Other deductions	\$	How often?
<input type="radio"/> Student loan interest	\$	How often?	Type:		

33. **Complete this question if new member's income changes during the year,** like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person. ➡

New member's total income <b>this year</b>	New member's total income <b>next year</b> (if you think it will be different)
\$	\$

**Thanks! This is all we need to know about you.**

### STEP 3: American Indian or Alaska Native (AI/AN)

#### 1. Is new member an American Indian or Alaska Native?

- NO. If no**, continue to Step 4.
- YES. If yes**, have any Native American household members requesting medical assistance ever received a service from Indian Health Services (IHS), Urban Indian Health or tribal healthcare?      Yes      No

### STEP 4: New member's health coverage

#### 1. Is new member offered health coverage from a job?

Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.

- YES. Is this a state employee benefit plan?**..... Yes  No
- NO.**

#### 2. Is new member enrolled in health coverage now?

- YES. If yes**, continue to question 3.
- NO. If no**, SKIP to Step 5.

#### 3. Information about current health coverage. *(Make a copy of this page if more than 2 people have health coverage now.)*

Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other. *(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)*

### STEP 5: Return in self-addressed stamped envelope

If you want to register to vote, you can complete a voter registration form at <https://www.usa.gov/register-to-vote>

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## Appendix A

### Assistance with completing this application

#### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact the Marketplace. If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State <input type="text"/> <input type="text"/>	6. ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7. Phone number ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
8. Organization name		
9. ID number (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.		
10. Your signature		11. Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

#### For certified application counselors, navigators, agents, and brokers only.

Complete this section if you’re a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	
4. ID number (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	5. Agents/Brokers only: NPN number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



## Appendix B: Voter Registration

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### 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 will be provided by this agency.

Yes  No **If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

**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.