South Dakota Department of Social Services

Strong Families - South Dakota's Foundation and Our Future

Economic Assistance Application

THINGS TO KNOW

What is Economic Assistance?

Economic Assistance programs help low-income individuals, families, children, pregnant women, people with disabilities, and the elderly by providing medical, nutritional, financial, and case management services. You can use this application to apply for Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or any combination of these programs.

When will I get assistance?

- **SNAP** – You will receive SNAP benefits within 30 days if you are eligible. If you are eligible, you will receive benefits within 7 days if you meet one of the following:
  - Households with gross monthly income less than $150 and resources of $100 or less
  - Households with rent, mortgage, and utilities that are more than the household's gross monthly income and resources
  - Households with migrant or seasonal farm workers with resources of $100 or less, whose income is stopping or starting.
- **Medical Assistance** – You will receive notice of your eligibility determination within 45 days.
- **TANF** – You will receive notice of your eligibility determination within 30 days.

Apply faster online

You can apply online at dss.sd.gov/applyonline

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)
- Expense information (for example, rental agreements or utility bills)

Why do we ask for this information?

We ask about income, resource, expense, and other information to let you know what benefits you qualify for.

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, we'll follow up with you. You have the right to file this application by completing just your name, address, and signature on page 3. The date we get page 3 starts the time we have to decide your eligibility. In order to determine if you are eligible, we must have the rest of the application and a signature on page 19. If you're applying for the Supplemental Nutritional Assistance or Temporary Assistance for Needy Families program, an interview is required. We'll contact you to set up the interview.

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.
2. **Deutsch (German) -** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-999-5612.
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.
4. **ကညီ (Karen) -** ၌ာ်သူဉ်ဟ်သး–နမ့်ကတိၤကညီကျိာ်အယိ,နမၤန့်ကျိာ်အတၢ်မၤစၢၤလၢတလာ်ဘူဉ်လာ်စ့ၤနီတမံၤဘဉ်သ့နှဉ်လီၤကိး 1-877-999-5612.
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.
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.
7. **Srpsko-hrvatski (Serbo-Croatian) -** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-999-5612.
8. **አማርኛ (Amharic) -** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-999-5612.
9. Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-877-999-5612.
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.
11. **한국어 (Korean) -** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-999-5612. 번으로 전화해 주십시오.
12. **Русский (Russian) -** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-999-5612.
13. **Cushite Oroomiffa (Oromo) -** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-999-5612.
14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 1-877-999-5612.
15. **Français (French) -** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-999-5612.

Tell us about you

FIRST NAME	MI	LAST NAME
BIRTH DATE	SOCIAL SECURITY NUMBER	
RESIDENTIAL ADDRESS		
CITY / STATE / COUNTY / ZIP CODE		
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)		
CITY / STATE / COUNTY / ZIP CODE		
PHONE NUMBER	SECONDARY PHONE NUMBER (OPTIONAL)	
DIRECTIONS TO YOUR HOME (IF NO STREET ADDRESS)	DO YOU LIVE ON AN INDIAN RESERVATION? ☐ YES ☐ NO	
WHAT IS THE BEST TIME TO CONTACT YOU BETWEEN 8AM AND 5PM?	E-MAIL ADDRESS (OPTIONAL)	

What programs are you applying for?

☐ SNAP ☐ TANF ☐ MEDICAL ASSISTANCE

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

☐ YES ☐ NO

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

☐ ONE ☐ TWO ☐ THREE

Do you need interpreter services?

☐ YES ☐ NO	IF YES, PREFERRED LANGUAGE

Do you need a South Dakota EBT card?

☐ YES ☐ NO

If you choose YES or leave blank, an EBT card will be mailed to you and your previous card will not work. If you chose NO, you will not receive an EBT card.

Signature

I CERTIFY THAT I WILL GIVE THE SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES ALL INFORMATION NEEDED TO REVIEW MY APPLICATION FOR TANF, SNAP, AND MEDICAL ASSISTANCE. THIS INFORMATION WILL BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNING HERE WILL START YOUR APPLICATION. YOU MUST ALSO SIGN PAGE 19 BEFORE YOU CAN RECEIVE ANY BENEFITS. FOR SNAP, YOU MUST COMPLETE THE ENTIRE APPLICATION, HAVE AN INTERVIEW, AND PROVIDE ID TO RECEIVE BENEFITS. AN APPLICATION FOR TANF WILL REQUIRE AN ADDITIONAL FORM. IF REQUESTING MEDICAL ASSISTANCE FOR A CHILD, YOUR SNAP INFORMATION WILL BE USED TO DETERMINE THEIR ELIGIBILITY FOR MEDICAL ASSISTANCE UNLESS YOU REQUEST US NOT TO DO SO.

SIGNATURE

Agency use only

EXPEDITED: APPLICATION:	RECEIPT DATE	CASE NUMBER

1. Who lives in your home?

PLEASE LIST EVERYONE IN YOUR HOME, EVEN IF YOU ARE NOT REQUESTING ASSISTANCE FOR THEM.

- COMPLETION OF SOCIAL SECURITY NUMBER AND CITIZENSHIP IS OPTIONAL FOR THOSE NOT REQUESTING ASSISTANCE
- COMPLETION OF COUNTRY OF BIRTH, MARITAL STATUS, LAST GRADE COMPLETED, SEX, RACE, AND ETHNICITY SECTIONS ARE OPTIONAL AND WILL NOT AFFECT YOUR ELIGIBILITY OR LEVEL OF BENEFITS. IF YOU DO NOT SELECT RACE OR ETHNCITY, OUR OFFICE MUST MAKE A SELECTION ON YOUR BEHALF, FOR REQUIRED DATA COLLECTION PURPOSES.

*Marital Status Codes: N- Never Married/Single M- Married S- Separated D- Divorced W- Widow/ Widower
** Race Codes: W- White A- American Indian/Alaska Native B- Black H- Hawaiian/Pacific Islander O- Asian

Check Program below	First Name, Middle Initial, Last Name	Relation To You (Spouse, Child, Sibling, friend etc.)	Social Security Number	Date of Birth / Country of Birth	Sex (Check One)	*Marital Status / Last Grade Completed	**Race / Ethnicity: (Hispanic or Latino? Check Y or N)	U.S. Citizen (Check One)	Does this person prepare and eat meals with you?
☐ SNAP ☐ Medical ☐ TANF ☐ None		Self			☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	N/A
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SNAP ☐ Medical ☐ TANF ☐ None					☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

2. Aliases

ARE THERE OTHER NAMES USED BY ANYONE IN THE HOME (MAIDEN NAMES, ALIASES, ETC.)?

☐ YES ☐ NO

HOUSEHOLD MEMBER	OTHER NAME(S) USED

3. Immigration Information

IS ANY INDIVIDUAL REQUESTING ASSISTANCE, NOT A U.S. CITIZEN? IF YES, COMPLETE ALL QUESTIONS BELOW.

☐ YES ☐ NO

NAME & ALIEN #	DOCUMENT TYPE	DOCUMENT NUMBER	EXPIRATION DATE	LIVED IN U.S. SINCE 1996	ACTIVE U.S. MILITARY OR VETERAN STATUS
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

4. Tribal Health Programs (If applying for Medical Assistance)

HAS ANY NATIVE AMERICAN HOUSEHOLD MEMBER RECEIVED A SERVICE OR IS ELIGIBLE TO RECEIVE SERVICES FROM INDIAN HEALTH SERVICES (IHS) URBAN INDIAN HEALTH, OR OTHER TRIBAL HEALTH PROGRAMS?

☐ YES ☐ NO

NAME OF HOUSEHOLD MEMBER	NAME OF HOUSEHOLD MEMBER

5. Authorized Representative

DO YOU WISH TO HAVE SOMEONE HELP YOU FILL OUT YOUR APPLICATION, GIVE INFORMATION AT YOUR INTERVIEW AND/OR SPEAK 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	

FOR WHICH PROGRAM(S) SHOULD THIS APPLY?

☐ SNAP ☐ MEDICAL ASSISTANCE

6. School Information

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, ATTEND SCHOOL? IF YES, COMPLETE BELOW

☐ YES ☐ NO

NAME	NAME OF SCHOOL	ENROLLMENT STATUS	EXPECTED GRADUATION DATE	IF THIS IS A BOARDING SCHOOL, DO THEY BOARD?
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME		☐ YES ☐ NO
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME		☐ YES ☐ NO
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME		☐ YES ☐ NO
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME		☐ YES ☐ NO

7. Tax Filing Information (If applying for Medical Assistance)

DO **YOU** PLAN TO FILE A FEDERAL INCOME TAX RETURN NEXT YEAR OR WILL YOU BE CLAIMED AS A DEPENDENT ON SOMEONE ELSE'S TAX RETURN NEXT YEAR? IF YES, PLEASE COMPLETE BELOW

☐ YES ☐ NO

WILL YOU FILE JOINTLY WITH A SPOUSE? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL YOU CLAIM ANY DEPENDENTS ON YOUR TAX RETURN? ☐ YES ☐ NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL YOU BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

DOES **ANYONE ELSE** IN THE HOME PLAN TO FILE A FEDERAL INCOME TAX RETURN NEXT YEAR OR WILL ANYONE ELSE BE CLAIMED AS A DEPENDENT ON SOMEONE ELSE'S TAX RETURN NEXT YEAR? IF YES, PLEASE COMPLETE BELOW

☐ YES ☐ NO

NAME	
WILL THEY FILE JOINTLY WITH A SPOUSE? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL THEY CLAIM ANY DEPENDENTS ON THEIR TAX RETURN? ☐ YES ☐ NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL THEY BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

NAME	
WILL THEY FILE JOINTLY WITH A SPOUSE? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL THEY CLAIM ANY DEPENDENTS ON THEIR TAX RETURN? ☐ YES ☐ NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL THEY BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

NAME	
WILL THEY FILE JOINTLY WITH A SPOUSE? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL THEY CLAIM ANY DEPENDENTS ON THEIR TAX RETURN? ☐ YES ☐ NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL THEY BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

8. Information about Parent(s) Not in the Home

DOES ANY CHILD ON THIS APPLICATION HAVE A PARENT LIVING OUTSIDE THE HOME? IF YES, COMPLETE THE QUESTIONS BELOW

☐ YES ☐ NO

PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)

9. Other Parents with Children Living in the Home

OTHER THAN YOU AND YOUR SPOUSE, ARE THERE ANY OTHER PARENTS WITH CHILDREN LIVING IN THE HOME? IF YES, COMPLETE THE QUESTIONS BELOW

☐ YES ☐ NO

PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)

10. Pregnancy (If applying for Medical Assistance)

IS ANYONE IN THE HOME PREGNANT?

☐ YES ☐ NO

NAME	EXPECTED DUE DATE	NUMBER OF BABIES EXPECTED

11. Migrant or Seasonal Farm Worker

IS ANYONE IN THE HOME A MIGRANT OR SEASONAL FARM WORKER?

☐ YES ☐ NO

NAME(S)

12. Criminal History

ARE YOU OR ANYONE IN THE HOME HIDING OR RUNNING FROM THE LAW?

- TO AVOID PROSECUTION OR FELONY PROSECUTION
- TO AVOID BEING TAKEN INTO CUSTODY, OR GOING TO JAIL FOR A FELONY OR ATTEMPTED FELONY
- VIOLATING PAROLE OR PROBATION

☐ YES ☐ NO

NAME(S)

HAS ANYONE IN THE HOME BEEN CONVICTED OF ANY OF THE FOLLOWING AFTER SEPTEMBER 22, 1996?

- FRAUDULENTLY RECEIVING DUPLICATE SNAP, TANF, MEDICAL, OR SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS IN ANY STATE;
- BUYING OR SELLING SNAP BENEFITS OF $500 OR MORE; TRADING SNAP BENEFITS FOR GUNS, AMMUNITION, EXPLOSIVES, OR DRUGS

☐ YES ☐ NO

NAME(S)

HAS ANYONE IN THE HOME BEEN CONVICTED OF A FELONY AFTER FEBRUARY 7, 2014 AND ARE NOT IN COMPLIANCE WITH THE TERMS OF THEIR SENTENCE OR PAROLE?

☐ YES ☐ NO

NAME(S)	STATE WHERE CONVICTED

13. Activities of Daily Living (If applying for Medical Assistance)

DOES ANYONE IN THE HOME HAVE CONDITIONS THAT CAUSE LIMITATIONS IN DAILY ACTIVITIES (LIKE BATHING, DRESSING, PERSONAL CARE, ETC.)? IF YES, LIST NAME(S) BELOW.

☐ YES ☐ NO

NAME(S)

14. Institutions

ARE YOU OR ANYONE IN THE HOME CURRENTLY LIVING IN AN INSTITUTION? IF YES, LIST NAME(S) BELOW. *AN INSTITUTION IS A FACILITY THAT PROVIDES AT LEAST 50% OF MEALS TO YOU SUCH AS ALCOHOL/DRUG TREATMENT CENTER, HOMELESS SHELTER, BATTERED WOMEN'S SHELTER, PRISON, ETC.)*

☐ YES ☐ NO

NAME OF PERSON IN FACILITY	NAME OF FACILITY	
TYPE OF FACILITY	DATE ENTERED	AMOUNT BILLED

15. Assistance in Other States

ARE THERE OTHER STATES/TERRITORIES WHERE YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, HAVE RECEIVED FOOD, MEDICAL, AND/OR CASH ASSISTANCE? IF YES, COMPLETE BELOW

☐ YES ☐ NO

NAME	BENEFIT TYPE	STATE/TERRITORY	START DATE	STOP DATE

16. Tribal Commodities

DO YOU OR ANYONE IN THE HOME RECEIVE TRIBAL COMMODITIES? IF YES, LIST NAME(S) BELOW.

☐ YES ☐ NO

NAME(S)

17. Disqualifications

ARE YOU OR ANYONE IN THE HOME DISQUALIFIED FROM RECEIVING SNAP OR TRIBAL COMMODITIES DUE TO AN INTENTIONAL PROGRAM VIOLATION? IF YES, LIST NAME(S) BELOW.

☐ YES ☐ NO

NAME(S)

18. Medicare Information (If applying for Medical Assistance)

DO YOU OR ANYONE IN THE HOME 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		

19. Income from Sources Other Than Employment

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, RECEIVE MONEY FROM SOURCES OTHER THAN WORK?
*EXAMPLES INCLUDE THE FOLLOWING:

- SOCIAL SECURITY
- SUPPLEMENTAL SECURITY INCOME (SSI)
- RETIREMENT ACCOUNTS
- PENSION FUNDS
- CHILD SUPPORT
- ALIMONY
- 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.

20. Employment Income

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, HAVE JOB INCOME OR EXPECT TO START A JOB? IF YES, LIST ALL JOB INCOME BELOW AND PROVIDE PROOF OF INCOME FOR THE LAST 30 DAYS.

☐ YES ☐ NO

NAME OF PERSON WORKING	EMPLOYER NAME		
EMPLOYER ADDRESS	CITY	STATE	ZIP
EMPLOYMENT TYPE ☐ FULL-TIME ☐ PART-TIME ☐ TEMPORARY ☐ SEASONAL	AVERAGE HOURS WORKED PER WEEK		
WAGES/TIPS (BEFORE TAXES)	HOW OFTEN? ☐ WEEKLY ☐ BI-WEEKLY ☐ TWICE MONTHLY ☐ MONTHLY ☐ OTHER		

NAME OF PERSON WORKING	EMPLOYER NAME		
EMPLOYER ADDRESS	CITY	STATE	ZIP
EMPLOYMENT TYPE ☐ FULL-TIME ☐ PART-TIME ☐ TEMPORARY ☐ SEASONAL	AVERAGE HOURS WORKED PER WEEK		
WAGES/TIPS (BEFORE TAXES)	HOW OFTEN? ☐ WEEKLY ☐ BI-WEEKLY ☐ TWICE MONTHLY ☐ MONTHLY ☐ OTHER		

NAME OF PERSON WORKING	EMPLOYER NAME		
EMPLOYER ADDRESS	CITY	STATE	ZIP
EMPLOYMENT TYPE ☐ FULL-TIME ☐ PART-TIME ☐ TEMPORARY ☐ SEASONAL	AVERAGE HOURS WORKED PER WEEK		
WAGES/TIPS (BEFORE TAXES)	HOW OFTEN? ☐ WEEKLY ☐ BI-WEEKLY ☐ TWICE MONTHLY ☐ MONTHLY ☐ OTHER		

21. Employment that Ended

DO YOU OR ANYONE IN THE HOME HAVE JOB INCOME THAT ENDED IN THE LAST 60 DAYS? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF YOUR FINAL CHECK.

☐ YES ☐ NO

NAME	EMPLOYER
LAST DAY WORKED	FINAL CHECK DATE
REASON FOR LEAVING	

22. Strike Participation

ARE YOU OR ANYONE IN THE HOME CURRENTLY ON STRIKE? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF YOUR FINAL CHECK.

☐ YES ☐ NO

NAME	EMPLOYER
LAST DAY WORKED	LAST CHECK DATE

23. Work Impairments

ARE YOU OR ANYONE IN THE HOME UNABLE TO WORK DUE TO A HEALTH PROBLEM?

☐ YES ☐ NO

NAME	APPLIED FOR SSDI/SSI/VA/WORKER'S COMP?	IF YES, DATE APPLIED
	☐ YES ☐ NO	
	☐ YES ☐ NO	

24. Self-Employment

ARE YOU OR ANYONE IN THE HOME SELF-EMPLOYED OR WORK ODD JOBS FOR CASH?

☐ YES ☐ NO

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

25. Gambling and Lottery Winnings

HAVE YOU OR ANYONE IN THE HOME RECEIVED GAMBLING OR LOTTERY WINNINGS IN THE PAST 30 DAYS? IF YES, COMPLETE BELOW.

☐ YES ☐ NO

NAME	DATE RECEIVED	AMOUNT OF WINNINGS	BALANCE AS OF TODAY

26. Vehicles

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, OWN OR CO-OWN ANY CARS, TRUCKS, BOATS, OR OTHER RECREATIONAL VEHICLES?

☐ YES ☐ NO

OWNER NAME(S)	MAKE/MODEL	YEAR	VALUE	AMOUNT OWED	LEASED
			$	$	☐ YES ☐ NO
			$	$	☐ YES ☐ NO
			$	$	☐ YES ☐ NO
			$	$	☐ YES ☐ NO

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

27. Real Property

OTHER THAN THE HOUSE YOU LIVE IN, DO YOU OR ANYONE IN THE HOME OWN/CO-OWN ANY LAND, BUILDINGS, OR HOMES (INCLUDING MOBILE HOMES)?

☐ YES ☐ NO

OWNER NAME(S)	VALUE	AMOUNT OWED

ADDRESS	CITY	STATE	ZIP

IS THIS PROPERTY FOR SALE OR RENT?	IF RENTED, DOES THIS PROPERTY PRODUCE INCOME?
☐ YES ☐ NO	☐ YES ☐ NO

28. Resources

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, HAVE ANY RESOURCES? EXAMPLES OF RESOURCES INCLUDE THE FOLLOWING:

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

☐ YES ☐ NO

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

29. 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

30. Private Health Insurance (If applying for Medical Assistance)

DO 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?	TYPE OF COVERAGE (MEDIGAP, RX, ETC)
	☐ MONTHLY ☐ QUARTERLY ☐ YEARLY	

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

31. Health Insurance History (If applying for Medical Assistance)

HAS ANY HOUSEHOLD MEMBER REQUESTING MEDICAL ASSISTANCE DROPPED HEALTH INSURANCE COVERAGE WITHIN THE LAST 3 MONTHS? IF YES, COMPLETE BELOW.

☐ YES ☐ NO

NAME	REASON

32. Resource Transfers

HAVE YOU OR ANYONE IN THE HOME SOLD, TRADED, OR GIVEN AWAY ANYTHING OF VALUE (E.G. MONEY, LAND, VEHICLES, LAND, OR BUILDINGS) WITHIN THE LAST 3 MONTHS? IF YES, COMPLETE BELOW.

☐ YES ☐ NO

NAME	DATE TRANSFERED	WHAT WAS TRANSFERRED?	VALUE

33. Shelter Expenses

DO YOU OR ANYONE IN THE HOME PAY FOR SHELTER EXPENSES? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE EXPENSE.

☐ YES ☐ NO

TYPE	AMOUNT PER MONTH	LANDLORD/BANK NAME & PHONE NUMBER	RENTAL ASSSISTANCE/SUBSIDIZED
RENT			☐ YES ☐ NO
LOT RENT			
MORTGAGE			
PROPERTY TAXES			
HOMEOWNER'S INSURANCE			
CONDO FEES			

34. Utility Expenses

DO YOU OR ANYONE IN THE HOME PAY FOR UTILITY EXPENSES? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE EXPENSE.

☐ YES ☐ NO

☐ ELECTRIC HEAT ☐ GAS ☐ PROPANE ☐ FUEL OIL ☐ WOOD HEAT

☐ AIR CONDITIONING	☐ GARBAGE	☐ WATER	☐ ELECTRICITY
☐ SEWER	☐ TELEPHONE	☐ COOKING FUEL	☐ ALL OF THE ABOVE

HAVE YOU OR ANYONE IN THE HOME RECEIVED ENERGY ASSISTANCE (LIEAP) OR TRIBAL ENERGY ASSISTANCE WITHIN THE LAST 12 MONTHS?

☐ YES ☐ NO

35. Medical Expenses

DOES ANYONE WHO HAS A DISABILITY OR IS AGE 60 OR OLDER, HAVE MEDICAL EXPENSES? EXAMPLES INCLUDE DOCTOR BILLS, PRESCRIPTION DRUGS, EYEGLASSES, TRANSPORTATION, INSURANCE PREMIUMS, DENTIST BILLS, ETC. IF YES, COMPLETE BELOW.

☐ YES ☐ NO

NAME	HOW MUCH PER MONTH	TO WHOM	HOW OFTEN BILLED
			☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER
			☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER

36. Child Support & Alimony Expenses

DOES ANYONE IN THE HOME PAY COURT ORDERED CHILD SUPPORT OR ALIMONY TO ANOTHER HOUSEHOLD? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

☐ YES ☐ NO

NAME	HOW MUCH PER MONTH	TO WHOM	HOW OFTEN BILLED
			☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER
			☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER

37. Dependent Care Expenses

DOES ANYONE IN THE HOME PAY FOR CHILD CARE OR ADULT CARE IN ORDER TO WORK, LOOK FOR WORK, OR ATTEND SCHOOL? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

☐ YES ☐ NO

NAME OF PERSON IN CARE	AMOUNT PAID	HOW OFTEN BILLED	PROVIDER
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	

DO ANY OF THE INDIVIDUALS LISTED ABOVE RECEIVE CHILD CARE ASSISTANCE? IF YES, COMPLETE BELOW

☐ YES ☐ NO

NAME(S)

38. Payee or Guardian Expenses

DOES ANYONE IN THE HOME PAY FOR PAYEE SERVICES OR SERVICES FOR A LEGAL GUARDIAN? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

☐ YES ☐ NO

NAME	AMOUNT PAID	HOW OFTEN BILLED	PROVIDER
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	

39. Tax Deductible Expenses (If applying for Medical Assistance)

DOES ANYONE IN THE HOME PAY FOR CERTAIN THINGS THAT CAN BE DEDUCTED ON A FEDERAL INCOME TAX RETURN (E.G., STUDENT LOAN INTEREST OR TRADITIONAL IRA CONTRIBUTIONS)? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

☐ YES ☐ NO

NAME	AMOUNT PAID	HOW OFTEN BILLED	TYPE OF EXPENSE
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	
		☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER	

40. Help Paying Expenses

DO YOU OR ANYONE IN THE HOME RECEIVE HELP PAYING EXPENSES? IF YES, COMPLETE BELOW. *INCLUDE HELP YOU GET FROM ANY AGENCY, ORGANIZATION, OR PERSON IN PAYING YOUR HOUSEHOLD EXPENSES.*

☐ YES ☐ NO

WHICH EXPENSE WAS PAID	NAME OF PERSON WHO PAYS

41. Foster Care (If applying for Medical Assistance)

WERE YOU OR ANYONE IN THE HOME, IN STATE SPONSORED FOSTER CARE AT AGE 18? IF YES, COMPLETE BELOW.

☐ YES ☐ NO

NAME	STATE

Statement of Understanding

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 with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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.

USDA NONDISCRIMINATION STATEMENT
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

(1) mail: Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; OR

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Signing up to Vote (Optional)

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.

Rights and Responsibilities

- I agree to inform the SD Department of Social Services when
  - my household's income exceeds the maximum amount for my household size; or
  - I or one of my household members is eligible only because of working 20 hours a week and the employment stops or hours decrease to less than 20 hours a week; or
  - I or one of my household members receive lottery or gambling winnings of $4,250 or more (before taxes or other deductions). Winnings must be reported within 10 days of their receipt.
- If receiving Medical Assistance, I agree to inform the SD Department of Social Services if the number of persons living with me or a pregnancy status changes, if there is a change in income, tax filing status changes, or a change in insurance.
- I understand that by applying for and accepting medical assistance, I assign any proceeds or any other third-party support, for each person for whom medical coverage was requested, to the SD Department of Social Services.
- I understand that if any child on this application has a parent living outside the home, I will be asked to cooperate with the agency that collects medical support from a parent not living in the home. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that if any of my children on this application has a parent living outside the home, I will be asked to cooperate with the agency that collects child support from a parent not living in the home for SNAP and TANF eligibility. If I do not cooperate, I understand I will not be eligible for TANF and/or SNAP benefits. If I think that cooperating to collect child support will harm me or my children, I can tell my Benefits Specialist and I may not have to cooperate.
- I understand I have the right to appeal if my SNAP and/or TANF application is not acted on within 30 days or my medical application is not acted on within 45 days by Economic Assistance.
- I understand I have the right to appeal within 90 days, if I disagree with any action made regarding my SNAP benefits. I also understand that I have the right to appeal within 30 days if I disagree with any decision made regarding my TANF and/or Medical Assistance application.
- Federal and state laws and regulations limit the use and disclosure of confidential or protected health information about applicants and recipients of assistance programs.
- Social Security numbers must be provided for all members applying for or receiving assistance. (Public Law 104-193 governing TANF, authorized under the Food and Nutrition Act of 2008 as amended through Public Law 110-246, and ARSD 67:46:01:12 governing Medical Assistance): Individuals applying for assistance may request help in obtaining Social Security numbers. Social Security numbers will not be shared with Federal immigration. Social Security numbers and all other information provided will be used or disclosed in order to determine eligibility and benefit level, prevent duplicate participation, verify the accuracy of information provided, verified through computer cross matches with other Federal and State agencies (Department of Labor, Social Security, Internal Revenue Service, etc.) when a discrepancy is found, assist in collection of benefit overpayments, used for program compliance and management, and apprehend persons fleeing to avoid the law, if requested.

Penalties

If you do the following…	You will…
▪ Hide information or make false statements ▪ Use SNAP benefits that belong to someone else ▪ Use SNAP benefits to buy alcohol or tobacco ▪ Trade or sell SNAP benefits, South Dakota EBT cards, or groceries purchased with SNAP benefits	Lose SNAP and/or TANF benefits for: ▪ 12 months for the first offense ▪ 24 months for the second offense ▪ Permanently for the third offense ▪ May be referred for criminal prosecution
▪ Trade SNAP benefits for controlled substances such as drugs	Lose SNAP benefits for: ▪ 24 months for the first offense ▪ Permanently for the second offense
▪ Trade SNAP benefits for firearms, ammunition, or explosives ▪ Trade, buy, or sell SNAP benefits of $500 or more	Lose SNAP benefits permanently
▪ Give false information when applying for or receiving assistance	▪ Be fined up to $1000 or sentenced up to 12 months in county jail, or both, if convicted of a misdemeanor ▪ Be fined up to $2000 or sentenced up to 2 years in prison, or both, if convicted of a felony
▪ Give false information with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously	▪ Lose SNAP benefits for 10 years.
▪ Give false information affecting eligibility of Medical Assistance	▪ Lose Medical Assistance up to a year ▪ Be fined up to $5000 or sentenced up to 5 years in prison, or both, if convicted

You can also be fined up to $250,000 or sentenced to prison up to 20 years, or both, for doing these things. You may also be charged under other Federal or State programs and could be ordered to repay the cost of that assistance. You may also be barred from receiving SNAP for an additional 18 months if court ordered. You can also be charged with perjury.

Sign and Authorize Application (Required)

I give my consent for any person, agency, or institution to supply information to the Department of Social Services, about me or my household, and to allow inspection and copying of records about me or my household by any representative of the Department.

I authorize the Department to release information to providers, state, or federal agencies.

I release any person, agency, or institution from any liability to me or my household for supplying such information.

This consent is given only for use by the Department in the administration of its benefit programs.

I understand that the information on this form is subject to verification by Federal, State, and local officials to determine that such information on this application is correct and complete including citizenship and alien status of the members applying for benefits. If any information is found to be incorrect, benefits may be reduced or terminated, and I will be responsible for paying the benefits back. I declare and affirm under penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct. I understand I may be subject to criminal prosecution for knowingly providing incorrect information. I have read and understand the legal information and understand my responsibilities and agree to fulfill them. I understand the penalties for giving false information or breaking the rules of the assistance program(s).

SIGNATURE OF APPLICANT

SIGNATURE OF AUTHORIZED REPRESENTATIVE

South Dakota Department of Social Services

Authorization to Furnish/Release Information

All adult household members should read and sign this Authorization to Furnish/Release Information form. This form may be used to help verify information you provide to process your application. If you need additional copies of this form, please contact your local office, or download the form from the website at:
https://dss.sd.gov/formsandpubs/docs/MEDELGBLTY/208AuthorizationReleaseInformation.pdf

Case Name:

To Whom it May Concern:

I give my consent for any person, agency, or institution to supply information to the Department of Social Services, about me or my household, and to allow inspection and copying of records about me or my household by any representative of the Department.

I authorize the Department to release information to providers, state, or federal agencies.

I release any person, agency, or institution from any liability to me or my household for supplying such information.

This consent is given only for use by the Department in administration of its benefit programs.

Signature of Applicant/Recipient Date

Signature of Spouse/Guardian Date

Signature of Other Adult Household Member Date

Address

City/State/Zip Code

Telephone Number

Appendix A: American Indian or Alaska Native (AI/AN) Household Members

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member is American Indian or Alaska Native and you are requesting Medical Assistance.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	Yes ☐ If yes, tribe name:	Yes If yes, tribe name:
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

AI/AN PERSON 3	AI/AN PERSON 4	AI/AN PERSON 5	AI/AN PERSON 6
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:
☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____

Economic Assistance Helpful Reminders

PLEASE KEEP THIS SECTION FOR YOUR RECORDS!

Information for SNAP:

- You **must** report to the Department of Social Services (DSS) when:
  - Your household income exceeds the maximum amount for your household size **or**
  - You or one of your household members is eligible only because of working 20 hours a week and the employment stops or hours decrease to less than 20 hours a week; **or**
  - You or one of your household members receive lottery or gambling winnings of $4,250 or more (before taxes or other deductions). Winnings must be reported within 10 days of their receipt.
- If you have received lottery or gambling winnings of $4,250 or more, you will immediately be ineligible for SNAP. You will remain ineligible until you again meet the allowable resource and income eligibility limits.
- If eligible, you are entitled to one SNAP benefit per month. If you apply after the 15th of the month, and determined eligible, you may receive the first and second months' benefits at the same time.
- If you receive the wrong amount of benefits, you will have to pay them back.
- Your case may be subject to a Federal or State audit whether it is active or not.
- You cannot receive SNAP benefits and commodities in the same month unless the commodities are distributed through the Senior Box Program.
- If you able to work but not working, you may only be eligible for benefits for 3 months out of a 36-month time period unless you live with a dependent child under age 18 or other exemption criteria are met.
- If you are able to work, you must register for work and cooperate with work registration requirements. Failure to cooperate will result in disqualification. Quitting a job or voluntarily reducing employment hours, without good cause, may also result in disqualification.
- You can spend SNAP benefits like cash at authorized stores for food and for edible garden plants or seeds to grow food to eat. You cannot buy alcohol, tobacco, vitamins, medicine, pet food, paper products, or hot foods prepared for immediate consumption with your SNAP benefits.
- You are not allowed to pay for food purchased on credit with SNAP benefits. If you do, you may lose benefits.
- The SD EBT card, benefits, or food purchased with the SD EBT card cannot be sold or traded. **It is against the law**. If benefits and/or food purchased with SNAP benefits are sold or traded, it will be investigated and if found guilty, a 12 month, 24 month, or permanent disqualification for SNAP will be implemented and the amount of any misused benefits will be required to be repaid. Individuals may also be referred for criminal prosecution which could result in a fine and/or prison time.
- Once you've received your benefits, you can use them right away. We recommend you use your South Dakota EBT (SD EBT) card at least once every 30 days. If your case closes, you can still use any benefits remaining in your account for up to 9 months. The card may be used anywhere in the United States where EBT is accepted.
- The SD EBT card will last for years. It is important to keep the SD EBT card in a safe and secure location. If your SD EBT card is lost, stolen or damaged, you must call EBT customer service at **1-800-604-5099** to order a replacement. A replacement card will be mailed to you within 5-7 days. Make sure DSS has your current mailing address prior to ordering a replacement EBT card. Excessive request for replacement cards will be investigated.
- If you feel your benefits have been fraudulently used by card skimming, card cloning or other similar fraudulent methods, you may be eligible for benefit replacement. You must contact your local office within 30 days of discovery of fraudulent use.
- Funds taken from the SD EBT card must be for the exact amount of the purchase. You should not be charged sales tax on purchases made with SNAP benefits.
- If your SNAP case closes, your household may continue to be eligible for other assistance such as TANF and/or Medical.
- A copy of your application is available to you either in paper or electronic format.

Information for TANF:

- You must report to DSS when your household income exceeds the maximum amount for your TANF household size.

Information for SNAP & TANF:

- Information reported to your Benefits Specialist the first of the month or later will not change benefits until the following benefit month(s).
- Children receiving SNAP or TANF benefits are automatically eligible for the National School Lunch program if it is offered at the school the child attends.
- If required, you must complete a report form in six months after application.
- Your SNAP and/or TANF benefits may be reduced or stopped if you do not cooperate with the TANF work program.

Information for Medical programs:

- After approval, for **ALL** questions regarding covered medical services or billing issues please call – **1-800-597-1603**. You may also refer to the medical recipient handbook.
- After medical approval, to change your primary care provider, you can call your Benefits Specialist OR you can stop by your local DSS office to request the change. Remember, your request will not take effect until the 1st of the next month.

General Information for All programs:

- Social Security numbers (SSN) must be provided for all household members over the age of 6 months if you want benefits for the individual. Infants 7 months or older without a SSN must provide proof that a SSN has been applied for or the infant will be ineligible for benefits until the SSN is provided or proof of application is received.
- All adult household members should read and sign an Authorization to Furnish/Release Information. This form is included in the application for the applicant and spouse to sign. If there are other adult household members, additional forms will be provided.
- Please make sure we have your most current mailing address because mail from the Department of Social Services is **NOT** forwarded by the Post Office.
- I understand that I must inform my Benefits Specialist if I have been convicted of an Intentional Program Violation (IPV) for any benefit program, whether the conviction was in South Dakota or any other state.
- I understand that I only have to provide immigrant status for individuals asking for or receiving benefits. However, individuals are still required to answer questions and submit verification about income and resources which may affect eligibility and benefits. An individual's immigration status will be verified if he/she applies for and/or receives benefits. Verification will be obtained by USCIS (U.S. Citizenship & Immigration Services).
- I understand that I will receive a written notice explaining the benefits I will receive. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- Information you provide and information obtained by DSS through computer cross-matching with other agencies (Dept. of Labor and Regulation, Internal Revenue Services, Social Security Administration, etc.), employers, financial sources, and other third parties will be used and may be verified when discrepancies are found.
- If you wish to appeal our decision to reduce, deny, or close benefits, you may request a fair hearing by writing any office in the Department of Social Services or send your written request directly to the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre, SD 57501-2291. For SNAP only, you may make your request by calling any local Department of Social Services office or the office of Administrative Hearings at 1-605-773-6851.