Table of Contents

State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 13-0015-MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 18, 2014

Mr. Anthony E. Keck
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: S-94 – Eligibility Process State Plan Amendment (SPA), SC-13-0015-MM2

Dear Mr. Keck:

Enclosed is an approved copy of South Carolina's state plan amendment (SPA) SC-13-0015-MM2, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 18, 2013. SPA SC-13-0015-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into South Carolina's Medicaid state plan in accordance with the Affordable Care Act. This SPA was approved on February 12, 2014. The effective date of this SPA is October 1, 2013.

The approval of SC-13-0015-MM2 includes full approval of your state's alternative single streamlined paper application. The state is using an interim alternative single streamlined online application and by March 31, 2014 will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of South Carolina's approved state plan:

- S94, pages S94-1 and S94-2
- Attachment 1 – State of South Carolina's alternative single streamlined paper application
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application
- Attachment 3 – Statement regarding Agreements Related to Coordination of Eligibility and Enrollment

In addition, enclosed is a summary of state plan pages which are superseded by SPA SC-13-0015-MM2, which should also be incorporated into a separate section in the front of the state plan.

- Superseding Pages of State Plan Material, SC-13-0015-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Maria Drake at (410) 562 – 3697 or at Maria.Drake@cms.hhs.gov

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 18, 2014

Mr. Anthony E. Keck
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: S-94 – Eligibility Process State Plan Amendment (SPA), SC-13-0015-MM2

Dear Mr. Keck:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of South Carolina's state plan amendment (SPA) transmittal SC-13-0015-MM2, which was submitted to CMS on November 18, 2013. Our review of this submission included a review of the online alternative single streamlined application developed by the state.

Until March 31, 2014, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

Necessary Changes	**Date by which changes will be completed:**
Tobacco use question will be removed from the online Medicaid application.	March 31, 2014
Reference to worker's compensation as a wage type will be removed from the household income information section.	March 31, 2014

Please submit the revised alternative single streamline online application to CMS for review no later than March 1, 2014 to ensure approval by March 31, 2014. We continue to be available to provide technical assistance.

If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any additional questions or require any further assistance, please contact Maria Drake at (404) 562-3697 or at Maria.Drake@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator

Medicaid State Plan Eligibility: Summary Page (CMS 179)

- State/Territory name:

  South Carolina

- **Transmittal Number:**

  Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

  SC-13-001

- **Proposed Effective Date**

  10/01/2013 (mm/dd/yyyy)

- **Federal Statute/Regulation Citation**

  42 CFR 43

- **Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

- **Subject of Amendment**

Character Count: out of 2000

S94= Eligibility Process

- **Governor's Office Review**

- ○ Governor's office reported no comment
- ○ Comments of Governor's office received

  Describe:

- ○ No reply received within 45 days of submittal
- ○ Other, as specified

  Describe:

Character Count: out of 2000

Mr. Anthony E. Keck was desig

- **Signature of State Agency Official**

- ○ Submitted By:

  Sheila Chavis

- ○ Last Revision Date:

  Feb 11, 2014

- ○ Submit Date: Nov 18, 2013

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0015-MM2	**STATE:** South Carolina
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2.1 (d) TN MA 92-07, Effective Date 01/01/92, Approved 06/04/92 Section 2.1 (a) MA 92-07, Effective Date 01/01/92, Approved 06/04/92

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Facsimile	Fax version of paper application	X
+	Electronic Transfer	XML version of paper application	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

COORDINATION OF ELIGIBILITY AND ENROLLMENT	
TRANSMITTAL NUMBER: SC-13-0015-MM2	**STATE:** South Carolina
Notwithstanding the final checked statement on page 2, South Carolina has not entered into an agreement with the Federally-facilitated Marketplace to date. South Carolina will make a good faith effort to enter into a memorandum of agreement with the Federally-facilitated Marketplace before March 31, 2014. At such time the agreement is signed, it will be incorporated by reference into this attachment.	

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER:	**STATE:**
SC-13-0015-MM2	South Carolina
Through March 31, 2014, the state is using an interim alternative single streamlined application. After March 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

Healthy Connections

South Carolina Department of Health and Human Services

Application for Medicaid and/or Affordable Health Coverage

things to know

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at SCDHHS.gov or HealthCare.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

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 the Privacy Act Statement, go to www.healthcare.gov/privacy/.

What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your application for health coverage. If you don't hear from us, visit SCDHHS.gov or call **1-888-549-0820**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** SCDHHS.gov
- **Phone:** Call our Help Center at **1-888-549-0820.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-888-549-0820** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-888-549-0820.**

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

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

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number (___) ___ - ____

15. Other phone number (___) ___ - ____

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** SKIP to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer _____

How are you related to the tax filer _____

7. Are you pregnant? ☐ Yes ☐ No **If yes,** a. How many babies are expected during this pregnancy? _____

b. What is your Due Date? _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES. **If yes,** answer all the questions below. ☐ NO. **If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

10. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

11. Have you been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

12. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

16. Are you a full-time student? ☐ Yes ☐ No

17. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
SKIP to question 30.

☐ **Self-employed**
SKIP to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
(__ __ __)__ __ __ - __ __ __ __

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

$ _____

23. Average hours worked each Week

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
(__ __ __)__ __ __ - __ __ __ __

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

$ _____

27. Average hours worked each Week

28. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

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

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income

Type: _____ $ _____ How often? _____

Type: _____ $ _____ How often? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay 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 a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

32. **YEARLY INCOME:** **Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**

$ _____

Your total income **next** year (if you think it will be different)

$ _____

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) __ __ __ - __ __ - __ __ __ __
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer _____

How is PERSON 2 related to the tax filer _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes,** a. How many babies are expected during this pregnancy? _____
b. What is PERSON 2's Due Date? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ YES. **If yes,** answer all the questions below. ☐ NO. **If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

11. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

12. Have you been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

15. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

17. Was PERSON 2 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about this income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
(___)___-____

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

$ _____

23. Average hours worked each Week

CURRENT JOB 2: (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
(___)___-____

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

$ _____

27. Average hours worked each Week

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

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

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income

Type: _____ $ _____ How often? _____

Type: _____ $ _____ How often? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 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 a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

32. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, for each additional person ask for and complete a DHHS Form 3400-01.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?** If available, please provide a copy of the insurance card.

☐ YES. **If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

Claim number: _____

Date Medicare coverage started: _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no, continue to Step 5.**

STEP 5 Read & sign this application.

Please read the following terms and conditions. If you disagree with a statement, additional questions may appear or your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file or I can contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD).

2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.

3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may

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4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.

5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

   - A person of any age who was a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

6. I know that I must tell SCDHHS if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.

7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match our electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.

8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid and CHIP programs, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair review of the action. I must submit a written request for such a hearing to SCDHHS. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 mail completed application.

Mail your signed application to:

SCDHHS – CEP
PO Box 100101
Columbia, SC 29202-3101

If you want to register to vote, you can complete a voter registration form at scvotes.org.

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APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address		6. Employer phone number (___ ___ ___)___ ___ ___- ___ ___ ___ ___
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) (___ ___ ___)___ ___ ___- ___ ___ ___ ___	12. Email address	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name:_____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐Yes ☐No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name		4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address (the Marketplace will send notices to this address)		6. Employer phone number (___ ___ ___) ___ ___ - ___ ___ ___ ___
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) (___ ___ ___) ___ ___ - ___ ___ ___ ___	12. Email address	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Answer 13a)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

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

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

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.

NOTE: If you have more people to include, make a copy of this page and attach.

	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 _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
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? _____

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APPENDIX C

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	6. ZIP code
7. Phone number (__ __ __)__ __ __-__ __ __ __		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

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)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)