Table of Contents

State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-14-002-MM7

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1600 Broadway, Suite #700
Denver, CO 80202-4967

CENTERS FOR MEDICARE & MEDICAID SERVICES

REGION VIII - DENVER

June 17, 2014 [LJ 14-002]

Lynne Valenti, Secretary
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291

RE: South Dakota 14-002 (Hospital PE)

Dear Ms. Valenti:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 14-002). With this SPA, the state may offer Medicaid coverage for individuals' determined presumptively eligible by a qualified hospital in accordance to the Affordable Care Act.

Please be informed that this State Plan Amendment was approved on June 13, 2014 with an effective date of January 1, 2014. We are enclosing the summary page (formerly CMS 179) and the amended plan pages.

If you have any questions concerning this amendment, please contact Laurie Jensen at 303-844-7126.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Divisions of Medicaid & Children's Health Operations

Cc: Marielle Kress

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **South Dakota**

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.

SD-14-002

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435.1110

Federal Budget Impact

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

Subject of Amendment

This SPA defines the presumptive eligibility period and the criteria for hospitals making presumptive eligibility determinations.

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:

Signature of State Agency Official

Submitted By:	**Ann Schwartz**
Last Revision Date:	**Jun 12, 2014**
Submit Date:	**Mar 19, 2014**

Medicaid Eligibility

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

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ■ Pregnant Women
- ■ Infants and Children under Age 19
- ■ Parents and Other Caretaker Relatives
- ■ Adult Group, if covered by the state
- ■ Individuals above 133% FPL under Age 65, if covered by the state
- ■ Individuals Eligible for Family Planning Services, if covered by the state
- ■ Former Foster Care Children
- ■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

(•) Yes ( ) No

Select one or both:

☐ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: 90% of all the presumptive eligibility decisions made by the hospital will be the same decision reached by the Department when a full Medicaid eligibility decision is made.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

( ) No more than one period within a calendar year.

(•) No more than one period within two calendar years.

( ) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

(•) Yes ( ) No

(•) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

( ) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

Medicaid Eligibility

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

☒ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

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.

SOUTH DAKOTA MEDICAID
HOSPITAL PRESUMPTIVE ELIGIBILITY PROGRAM APPLICATION

A separate application must be completed for each hospital.

POLICY STATEMENT

Presumptive eligibility allows qualified hospitals to make temporary Medicaid eligibility determinations in accordance with federal law and state policy for: 1) Low Income Parents and other Caretaker Relatives; 2) Pregnant Women; 3) Medicaid Children Under age 19; 4) Former Foster Care Children Age 18-26; and/or 5) Individuals Needing Treatment for Breast or Cervical Cancer.

DEFINITIONS

A "qualified hospital" is defined as a hospital that:

1. Participates as a hospital provider under the South Dakota Medicaid State Plan;

2. Notifies the South Dakota Department of Social Services (DSS) of its election to make presumptive eligibility determinations;

3. Agrees to make presumptive eligibility determinations consistent with South Dakota policies and procedures;

4. Assists individuals in completing and submitting the full application for Medicaid and understanding any documentation requirements; and

5. Has not been disqualified by the South Dakota Department of Social Services.

REQUIREMENTS

Qualified hospitals must adhere to South Dakota's requirements for presumptive eligibility determinations. Failure to meet the minimum performance standards established by the Department of Social Services or to adhere to South Dakota Presumptive Eligibility policies may be cause for disqualification from the Hospital Presumptive Eligibility Program. Performance standards and compliance with South Dakota policies will be evaluated on a quarterly basis. Qualified hospitals failing to meet performance standards or adhere to South Dakota policies will be required to submit a corrective action plan to the Department of Social Services that includes remedial training provided by the Department. If the qualified hospital fails to meet minimum performance standards following remedial training and implementation of the corrective action plan, the hospital may be disqualified from participation in the Hospital Presumptive Eligibility program.

The qualified hospital must:

1. Designate an interviewer(s) and notify the South Dakota Department of Social Services of the name, title, and telephone number of all employees conducting presumptive eligibility determinations.

2. Notify the Department when new employees are designated to perform presumptive eligibility determinations.

3. Assure employees authorized to perform presumptive eligibility determinations are not employees with authority or responsibility to submit claims to the Medicaid program for reimbursement of Medicaid services. Assure no presumptive eligibility determination functions will be delegated to non-hospital staff, third party vendors, or contractors.

4. Assure that all designated employees complete presumptive eligibility training provided by the Department of Social Services prior to performing presumptive eligibility determinations. Retain documentation of all training completed on file at the hospital. *Note: Presumptive eligibility training and determinations are not reimbursable. Qualified hospitals are reimbursed for Medicaid covered services provided to individuals determined to be presumptively eligible.*

5. Assure capability of assisting applicants who need the assistance of an interpreter.

6. Provide training to all designated employees on security and privacy laws, regulations, and standards prior to the performing presumptive eligibility determinations. Assure all designated employees sign a statement regarding confidential information obtained during the presumptive eligibility process. Proof of signed confidentiality agreements must be retained on site by the qualified hospital for a minimum of 3 years.

   Any information obtained during the Presumptive Eligibility application process is considered confidential and may not be disclosed to any persons or agencies other than representatives of the Department of Social Services and its designees. Information is confidential whether the application is approved or denied and may not be shared with collection agencies or any other third-party.

7. Provide *Notice of Privacy Practices* to the applicant.

8. Verify that the individual is not currently enrolled in Medicaid or CHIP or that the individual has had a prior presumptive eligibility determination in the previous two calendar years. On a monthly basis, the Department will provide qualified hospitals with a list of applicants determined presumptively eligible in the previous two years.

9. Follow procedures found in the *Presumptive Eligibility Training Guide– Hospital Presumptive Eligibility.*

10. Screen applicants using the *Presumptive Eligibility Worksheet* and perform necessary calculations to determine if the applicant meets the criteria for presumptive eligibility.

11. Issue a presumptive eligibility determination letter on the approved form to the applicant that clearly indicates the outcome of the presumptive eligibility determination. If determined presumptively eligible, explain the next steps the applicant must take to complete the application process, including the end date of presumptive eligibility period and covered Medicaid services during the presumptive eligibility period.

12. Assist applicants in the completion and submission of a full Medicaid application and understanding any documentation requirements.

13. Provide all applicants with contact information for the South Dakota Department of Social Services.

14. If the applicant does not complete a full Medicaid application during the presumptive eligibility interview or at the hospital, provide the applicant with a copy of the application and direct the applicant where to submit the application upon its completion.

15. Forward the completed Presumptive Eligibility Medicaid application, *Presumptive Eligibility Worksheet*, and a copy of the determination letter to the Division of Economic Assistance, ATTN: Presumptive Eligibility within two working days of the presumptive eligibility determination.

16. Have a computer, internet, telephone, printer, and fax access available for applicants to facilitate the presumptive eligibility and full Medicaid application process.

17. Secure all documents in a locked file cabinet not accessible to public or employees not designated as presumptive eligibility employees or who have not signed a confidentiality statement.

18. Communicate with the Department of Social Services to resolve any issues or concerns and to establish efficient policies and procedures to perform presumptive eligibility determinations.

19. Each qualified hospital must maintain records of the hospital's activities related to presumptive eligibility determinations. Records must be retained for a minimum of 6 years as required by Administrative Rule of South Dakota (ARSD) §67:16:34:05.

    Track and report the following data each quarter:

    (1) Number of individuals screened for presumptive eligibility
    (2) Number of individuals approved for presumptive eligibility
    (3) Number of individuals rejected for presumptive eligibility
    (4) Reasons for each presumptive eligibility rejection

DRAFT

(5) Dates on which individuals are screened, approved, and rejected for presumptive eligibility

20. Maintain at least a 90% accuracy rate when performing Hospital Presumptive Eligibility Determinations. 90% of all the presumptive eligibility decisions made by the hospital must be the same decision reached by the Department when a full Medicaid eligibility decision is made.

21. Provide written notice to the Department of intent to withdraw from the Hospital Presumptive Eligibility Program. Written notice may be given at any time.

22. The qualified hospital must monitor the quality of the case processing by reviewing a sample of completed cases. It is recommended that at least one case review per month be completed for each designated employee. If frequent errors are noted, corrective action must be taken.

DRAFT

QUALIFICATIONS

Qualified hospitals must answer the following questions to complete the presumptive eligibility application. Responses to these questions will be used to assess the hospital's ability to provide presumptive eligibility determinations in accordance with the above stated requirements.

1. General Information:

Hospital Name:
Click here to enter text.

Address: Click here to enter text.

Billing National Provider Identifier (NPI): Click here to enter text.

2. Primary Contact Information for Hospital Presumptive Eligibility Program:

Name of Individual completing Application: Click here to enter text.

Name of Individual with Primary Responsibility for Hospital Presumptive Eligibility Program: Click here to enter text.

Title: Click here to enter text.

Telephone Number: Click here to enter text.

Email: Click here to enter text.

3. Designate the Medicaid Group(s) the Hospital elects to make Presumptive Eligibility Determinations for. Check all that apply.

- ☐ Low Income Parents and Caretaker Relatives
- ☐ Medicaid Children Under Age 19
- ☐ Pregnant Women
- ☐ Former Foster Care Children Age 18 to 26
- ☐ Individuals Needing Treatment for Breast or Cervical Cancer. *Note: The hospital must be an All Women Count! Program provider.*

DRAFT

4. **Designate Presumptive Eligibility Employees. Attach additional sheets as necessary.**

    a) Designated Presumptive Eligibility Interviewer:

    Name: Click here to enter text.

    Title: Click here to enter text.

    Telephone Number: Click here to enter text.

    Email: Click here to enter text.

    Qualifications: Click here to enter text.

    b) Additional Designated Presumptive Eligibility Employees:

    Name: Click here to enter text.

    Title: Click here to enter text.

    Telephone Number: Click here to enter text.

    Email: Click here to enter text.

    Qualifications: Click here to enter text.

5. **Describe the hospital's proposed internal process for making Presumptive Eligibility Determinations. Include the specific follow-up and outreach efforts the hospital intends to use to meet the Department's performance standards of ensuring a 95% full Medicaid determination rate.**

    Click here to enter text.

DRAFT

SUBMISSION

Completed applications may be mailed to:
Division of Medical Services
ATTN: Hospital Presumptive Eligibility
700 Governors Drive
Pierre, SD 57501

Questions about this application should be addressed to the Division of Medical Services at (605) 773-3495.

By signing this application, the qualified hospital, through its below named representative, elects to perform Presumptive Eligibility Determinations in compliance with all terms, conditions, and administrative responsibilities detailed above. It further agrees to be bound by all applicable State or Federal laws not expressly outlined in this application pertaining to the Medicaid eligibility system, presumptive eligibility determinations, security, and privacy.

Designated Representative (Please Print): _____

Signature: _____

Date Signed: _____

DRAFT

DSS Internal Use Only	
DMS Date Received:	**EA Date Received:**
Provider Status Verification: _____ **APPROVED** _____ **DENIED** **Notes:**	
Training Scheduled:	

Presumptive Eligibility Training Guide

Hospital Presumptive Eligibility

South Dakota Division of Economic Assistance
June 2014

TABLE OF CONTENTS

PREFACE

Medicaid is a joint federal and state program established in 1965, under Title XIX of the Social Security Act. The purpose of the Medicaid Program is to assure the availability of quality medical care for low-income individuals and families through payments for specific covered services. The Medicaid program was implemented in South Dakota in 1967. The Department of Social Services (DSS) is the single-state agency responsible for administering the Medicaid program in South Dakota. The Division of Medical Services oversees the Medicaid Program. Eligibility determinations for the Medicaid program are performed by the Division of Economic Assistance.

The Hospital Presumptive Eligibility Program allows qualified hospitals to make temporary eligibility determinations in accordance with federal law and state policy for the Medicaid program while an applicant's full Medicaid application is processed by the Department of Social Services. This guide contains the policies and procedures governing the Hospital Presumptive Eligibility Program in South Dakota. Questions about this guide may be directed to:

South Dakota Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501
Phone: (605) 773-4678
Fax: (605) 773-7183

The policies and procedures found in this manual are subject to review and amendment by the South Dakota Department of Social Services. Check this manual frequently for updates.

DRAFT

GENERAL INFORMATION

HOSPITAL PRESUMPTIVE ELIGIBILITY

Under 42 CFR §435.1110, a "qualified hospital" may elect to make presumptive eligibility determinations based on a State's policies and procedures. Presumptive Eligibility is a temporary medical assistance category that allows an individual to receive covered medical services while his/her application for full Medicaid is processed.

A hospital may elect to make Presumptive Eligibility determinations for one or more of the following groups:

- Low Income Parents and Caretaker Relatives
- Medicaid Children Under Age 19
- Pregnant Women
- Former Foster Care Children Age 18 to 26

Hospitals must identify the eligibility groups that the hospital elects to make Presumptive Eligibility determinations for on the South Dakota Hospital Presumptive Eligibility Application.

Hospitals may not delegate the authority to determine presumptive eligibility to another entity.

COVERED SERVICES

The following services are eligible for reimbursement during a Presumptive Eligibility period:

- Low Income Parents and Caretaker Relatives, Children Under age 19, and Former Foster Care Individuals are eligible to receive all Medicaid covered services.

- Pregnant Women are eligible for ambulatory prenatal care. Ambulatory prenatal care includes pregnancy-related Medicaid covered services except charges associated with inpatient care in a hospital or other medical institution and charges associated with delivery of the baby, including miscarriage. A woman is allowed only one presumptive eligibility period per pregnancy.

DURATION OF PRESUMPTIVE ELIGIBILITY PERIOD

The presumptive eligibility period begins with the date on which a qualified hospital determines that the individual is eligible. An individual is allowed one presumptive eligibility period every two calendar years. A pregnant woman is allowed one presumptive eligibility period per pregnancy.

DRAFT

Presumptive Eligibility coverage ends on either:

- The date the eligibility determination for medical assistance is made by the Department of Social Services, if a complete application is filed by the last day of the month following the month in which the Presumptive Eligibility determination is made; or

- The last day of the month following the month in which the Presumptive Eligibility determination was made.

QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY APPLICATION

A "qualified hospital" is defined as a hospital that:

1. Participates as a provider under the South Dakota Medicaid State Plan;
2. Notifies the South Dakota Department of Social Services of its election to make presumptive eligibility determinations;
3. Agrees to make presumptive eligibility determinations consistent with South Dakota policies and procedures;
4. Assists individuals in completing and submitting the full application for medical assistance and understanding any documentation requirements; and
5. Has not been disqualified by the Department of Social Services.

Hospitals must submit an application to become a qualified hospital. Providers may contact the Division of Medical Services at (605) 733-3495 to request a South Dakota Hospital Presumptive Eligibility Application.

DISQUALIFICATION OF QUALIFIED HOSPITAL

The State of South Dakota is required to establish standards for qualified hospitals. The qualified hospital must agree to make presumptive eligibility determinations consistent with South Dakota policies and procedures. The State of South Dakota is required to take action, including, but not limited to, disqualification of a hospital as a qualified hospital if the State determines the hospital is not making, or is not capable of making presumptive eligibility determinations in accordance with applicable South Dakota policies and procedures or meeting the standards established by the Department of Social Services. The hospital may only be disqualified from the Hospital Presumptive Eligibility Program after the Department of Social Services has provided the hospital with additional training or taken other reasonable corrective measures.

Performance standards and compliance with South Dakota policies will be evaluated on a quarterly basis. Qualified hospitals failing to meet performance standards or adhere to South Dakota policies will be required to submit a corrective action plan to the Department of Social Services that includes remedial training provided by the Department. If the qualified hospital fails to meet minimum performance standards following remedial training and the corrective

action plan, the hospital may be disqualified from participation in the Hospital Presumptive Eligibility program.

Qualified hospitals may withdraw from the Presumptive Eligibility program at any time upon written notice to the South Dakota Department of Social Services.

PROGRAM REQUIREMENTS

The State of South Dakota has established the following requirements for qualified hospitals participating in the Presumptive Eligibility Program. Qualified hospitals must:

1. Designate an interviewer(s) and notify the South Dakota Department of Social Services of the name, title, and telephone number of all employees conducting presumptive eligibility determinations.

2. Notify the Department when new employees are designated to perform presumptive eligibility determinations.

3. Assure employees authorized to perform presumptive eligibility determinations are not employees with authority or responsibility to submit claims to the Medicaid program for reimbursement of Medicaid services. Assure no presumptive eligibility determination functions will be delegated to non-hospital staff, third party vendors, or contractors.

4. Assure that all designated employees complete presumptive eligibility training provided by the Department of Social Services prior to performing presumptive eligibility determinations. Retain documentation of all training completed on file at the hospital. *Note: Presumptive eligibility training and determinations are not reimbursable. Qualified hospitals are reimbursed for Medicaid covered services provided to individuals determined to be presumptively eligible.*

5. Assure capability of assisting applicants who need the assistance of an interpreter.

6. Provide training to all designated employees on security and privacy laws, regulations, and standards prior to the performing presumptive eligibility determinations. Assure all designated employees sign a statement regarding confidential information obtained during the presumptive eligibility process. Proof of signed confidentiality agreements must be retained on site by the qualified hospital for a minimum of 3 years.

   Any information obtained during the Presumptive Eligibility application process is considered confidential and may not be disclosed to any persons or agencies other than representatives of the Department of Social Services and its designees. Information is confidential whether the application is approved or denied and may not be shared with collection agencies or any other third-party.

7. Provide *Notice of Privacy Practices* to the applicant.

8. Verify that the individual is not currently enrolled in Medicaid or CHIP or that the individual has had a prior presumptive eligibility determination in the previous two

calendar years. On a monthly basis, the Department will provide qualified hospitals with a list of applicants determined presumptively eligible in the previous two years.

9. Follow procedures found in the *Presumptive Eligibility Training Guide– Hospital Presumptive Eligibility.*

10. Screen applicants using the *Presumptive Eligibility Worksheet* and perform necessary calculations to determine if the applicant meets the criteria for presumptive eligibility.

11. Issue a presumptive eligibility determination letter on the approved form to the applicant that clearly indicates the outcome of the presumptive eligibility determination. If determined presumptively eligible, explain the next steps the applicant must take to complete the application process, including the end date of presumptive eligibility period and covered Medicaid services during the presumptive eligibility period.

12. Assist applicants in the completion and submission of a full Medicaid application and understanding any documentation requirements.

13. Provide all applicants with contact information for the South Dakota Department of Social Services.

14. If the applicant does not complete a full Medicaid application during the presumptive eligibility interview or at the hospital, provide the applicant with a copy of the application and direct the applicant where to submit the application upon its completion.

15. Forward the completed Presumptive Eligibility Medicaid application, *Presumptive Eligibility Worksheet*, and a copy of the determination letter to the Division of Economic Assistance, ATTN: Presumptive Eligibility within two working days of the presumptive eligibility determination.

16. Have a computer, internet, telephone, printer, and fax access available for applicants to facilitate the presumptive eligibility and full Medicaid application process.

17. Secure all documents in a locked file cabinet not accessible to public or employees not designated as presumptive eligibility employees or who have not signed a confidentiality statement.

18. Communicate with the Department of Social Services to resolve any issues or concerns and to establish efficient policies and procedures to perform presumptive eligibility determinations.

19. Each qualified hospital must maintain records of the hospital's activities related to presumptive eligibility determinations. Records must be retained for a minimum of 6 years as required by Administrative Rule of South Dakota (ARSD) §67:16:34:05.

    Track and report the following data each quarter:

    (1) Number of individuals screened for presumptive eligibility

DRAFT

(2) Number of individuals approved for presumptive eligibility
(3) Number of individuals rejected for presumptive eligibility
(4) Reasons for each presumptive eligibility rejection
(5) Dates on which individuals are screened, approved, and rejected for presumptive eligibility

20. Maintain at least a 90% accuracy rate when performing Hospital Presumptive Eligibility Determinations. 90% of all the presumptive eligibility decisions made by the hospital must be the same decision reached by the Department when a full Medicaid eligibility decision is made.

21. Provide written notice to the Department of intent to withdraw from the Hospital Presumptive Eligibility Program. Written notice may be given at any time.

22. The qualified hospital must monitor the quality of the case processing by reviewing a sample of completed cases. It is recommended that at least one case review per month be completed for each designated employee. If frequent errors are noted, corrective action must be taken.

NON-DISCRIMINATION

Title IV of the Federal Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the groups of race, sex, color, national origin, or handicap in the administration of federally-funded programs. This includes Medicaid and CHIP programs.

DRAFT

TRAINING AND COMMUNICATIONS

The qualified hospital must designate a primary contact for the Presumptive Eligibility Program for the Department of Social Services who is responsible for communication to the Department regarding program changes, questions, personnel changes, and other issues.

Qualified hospitals must designate all employees involved in the Presumptive Eligibility process. All designated employees must obtain training from the Department of Social Services prior to performing Presumptive Eligibility functions. Each employee will be required to certify that they have received training on South Dakota policies and procedures and agree to perform presumptive eligibility determinations in accordance with the requirements outlined by the Department of Social Services. The qualified hospital must retain a copy of employee certifications.

After the Department has approved the hospital's Presumptive Eligibility Application, the Department will work with the primary contact to schedule face-to-face training with designated employees. During the training period, the qualified hospital and the Department of Social Services will make ten joint presumptive eligibility determinations. Joint determinations will not count towards the qualified hospital's Medicaid determination rate. In the event that the qualified hospital requires remedial training, the Department and the qualified hospital will make another ten joint presumptive eligibility determinations.

Additional trainings may be scheduled as the qualified hospital designates new employees for presumptive eligibility determinations.

CLAIMS PROCESSING

Qualified hospitals should delay submitting claims for services provided to individuals determined eligible by the Presumptive Eligibility Program for one week from the eligibility start date to ensure the eligibility information is transmitted to the Division of Medical Services and to prevent claims from being inappropriately denied.

Claims must be for a covered Medicaid Service and submitted in accordance with ARSD §67:16. Presumptive Eligibility claims should be submitted in the same manner as all other claims submitted by the entity. No special processing is needed.

DRAFT

SCREENING AND APPLICATION ASSISTANCE

STEP 1: MEDICAL ASSISTANCE SCREENING

Qualified hospitals are required to verify if an applicant is currently enrolled in Medicaid before providing services to the applicant.

All providers are encouraged to use the Medicaid Eligibility Verification System (MEVS) or the South Dakota Medicaid Interactive Voice Response (IVR) and Telephone Service Unit by calling 1-800-452-7691 to verify eligibility.

If an applicant is enrolled in Medicaid, do not have the applicant complete an application and do not complete a Presumptive Eligibility determination.

If a baby is born to a mother enrolled in Medicaid, do not have the mother complete an application and do not complete a Presumptive Eligibility determination. The baby will be eligible for the Automatic Newborn program when the birth is reported to the Department of Social Services. The hospital may contact the Division of Economic Assistance to report the birth.

If an applicant is not currently enrolled in Medicaid, assist the applicant in completing an application and determine eligibility for the Presumptive Eligibility Program.

STEP 2: PRESUMPTIVE ELIGIBILITY SCREENING

Presumptive Eligibility periods are limited to no more than one period within two calendar years per applicant. Pregnant Women are eligible for one Presumptive Eligibility period per pregnancy. Qualified hospitals are required to verify if an applicant has been enrolled in a Presumptive Eligibility period within two calendar years of the date of the presumptive eligibility application. On a monthly basis, the Department will provide qualified hospitals with a list of applicants determined presumptively eligible in the previous two years.

If an applicant has a presumptive eligibility period within the previous two calendar years, give the applicant information about how to complete a full Medicaid application.

DRAFT

STEP 3: PRESUMPTIVE ELIGIBILITY APPLICATION ASSISTANCE

Qualified hospitals must use the *Presumptive Eligibility Medicaid Application*. This form may be obtained from the Department of Social Services, Division of Economic Assistance, 605-773-4678.

At minimum, qualified hospitals must complete the questions denoted with an asterisk for a presumptive eligibility determination. The qualified hospital must also gather enough information to complete the Presumptive Eligibility Worksheet found in Appendix 1.

DRAFT

DETERMINING PRESUMPTIVE ELIGIBILITY

GENERAL ELIGIBILITY CRITERIA

Social Security Number: A Social Security Number (SSN) or attestation of an application for a SSN should be provided for each applicant, if the applicant is willing to provide it. Self-declaration of the SSN is sufficient and can be listed on the application where requested. No card or proof is necessary. Lack of an SSN on the application may not delay or impact a presumptive eligibility determination.

Citizenship/National or Qualified Alien: The applicant must be a citizen or national of the United States or a qualifying immigrant with one of the following immigration statuses:

- Afghan Special Immigrant
- Amerasian Immigrant admitted pursuant to Section 584
- Asylee admitted under Section 208 of the INA
- A battered alien (includes battered alien's child and parent of a battered alien child)
- Alien granted conditional entry under 203(a)(7) of the INA
- Alien granted status as a Cuban/Haitian entrant as defined in Section 501(a)
- An alien whose deportation is being withheld under 243(h) or 241(b)(3) of the INA
- Iraqi Special Immigrant
- Alien Lawfully admitted for permanent residence (LPR) under the INA living lawfully in the United States for five years or longer
- Alien who is a U.S. Active duty military member, includes spouses and unmarried dependent children under 19
- Alien who was an honorably discharged U.S. military veteran, includes spouse and unmarried dependent children under 19
- An American Indian born in Canada
- A member of a federally recognized tribe born outside U.S.
- An alien granted parole for at least one year by the UNS pursuant to Section 212(d)(5) of the INA
- A refugee under Section 207 of the INA
- An alien certified as a Victim of Severe Form of Trafficking

If an applicant is not a U.S. citizen or a naturalized citizen, the applicant must be asked for his/her alien status and must qualify under one of the groups outlined above. Undocumented aliens or immigrants that do not qualify under a group outlined above should be referred to the Department of Social Services for a full Medicaid eligibility determination.

Residency: In order to be eligible for South Dakota Medicaid, an applicant must be a resident of the State of South Dakota. A South Dakota address must be provided on the application.

DRAFT

State residency is established by physically residing in South Dakota and declaring intent to remain.

An applicant is not considered a resident if the applicant is in South Dakota for a temporary reason such as a vacation, business trip, or attending a South Dakota college without intent to remain in South Dakota after completion of the course of study.

Household Size: Household size includes the parent or caretaker relative, the parent or caretaker relative's spouse, if the spouse lives with the individual, and all of their dependent children, including unborn children. Others, such as a boyfriend or girlfriend, or other relatives are not counted in household size, even if they live within the household.

Earned Income: Income includes wages and tips before taxes and other deductions.

Calculation Steps:

(1) Always use the most current month to determine gross monthly (before taxes) income.
(2) If determining income for more than one job, add the gross amounts for each job.
(3) The total is the gross monthly income amount. Enter this amount on the Presumptive Eligibility Worksheet in Appendix 1.

Unearned Income: Medicaid counts some unearned income of individuals in the household. Unearned income is considered to be income received by an individual that is not received through wages or tips. This may include:

- Pensions
- Social Security
- Retirement Accounts
- Alimony

Examples of Non-Countable Income

Certain income is not counted in the applicant's income determination. Do not include income from the following:

- Federal Veteran's Benefits
- Child Support
- Worker's Compensation
- Scholarships, fellowship grants and awards used for educational purposes.
- Income of Children: The income of children is not included unless the amount of the child's income requires the child to file a tax form.
- Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF).
- Supplemental Security Income

Note: The Department will provide a more detailed list and examples of countable and non-countable income during training.

DRAFT

Self-Employment

Step 1:
Identify "adjusted gross income" from appropriate line of federal income tax form or by self-attestation from the applicant:

- Line 4 on Form 1040 EZ
- Line 21 on Form 1040 A
- Line 37 on Form 1040

If the applicant had wages, salaries, tips, etc. (line 7) that does not reflect the current monthly amount, this amount should be deducted and recalculated at the current monthly rate.

Step 2:
If applicable, add the following sources of income from the last year's tax form or by self-attestation from the applicant:

- Any Social Security benefits not already included in adjusted gross income (line 20a on Form 1040)
- Tax-exempt interest taxpayer expects to receive or accrue during year (line 8b on Form 1040)
- Foreign earned income excluded from gross income (based on Form 2555, line 26 or Form 2555-EZ, line 17) (Line 7 on Form 1040)

Step 3:
If applicable, make the following income modifications:

- Count lump sum payments (e.g., gifts, prizes, income and property tax refunds only in month received)
- Subtract educational scholarships, awards or fellowships used for education purposes
- Subtract certain types of income for American Indian/Alaskan Native individuals.
- For applicants who expect to be claimed as a tax dependent by a grandparent, another relative, or another taxpayer who is not a parent or step-parent, count cash support (exceeding $500) provided by the person claiming the applicant as a tax dependent.

Step 4:
Divide annual total by 12 to get a monthly amount.

If an applicant has, or expects, changes from the most recent tax forms for self-employment income, the applicant should address the change that makes the average monthly income from the most recent return inappropriate for assessing eligibility for presumptive eligibility.

Allowable Business Expenses include:

- Cost of stock and inventory;
- Cost of operating machinery or equipment;
- Rent for the business property;
- Taxes on the business property, such as real estate and vehicle taxes;
- Mortgage interest, vehicle loan interest , and interest on loans made to the business;
- Fire, theft, flood, or similar insurance, liability insurance, and contributions to industrial compensation and unemployment insurance; wages paid to employees; costs of employee benefits, such as health insurance, dependent care assistance, and life insurance;
- Business transportation, such as lease payments, license and registration, vehicle insurance, gas, oil, tires, report costs, garage rent, tolls, parking;

- Advertising costs;
- Utilities;
- Depreciation;
- Federal, state, or local income tax payments;
- Entertainment expenses;
- Personal transportation;
- Cost of purchasing capital equipment;
- Payments on the principal of loans; and
- Carryover of previous year's losses.

A business may report a net loss for the year. The prorated amount of the loss is subtracted from the budget group's countable income for the month. If the remaining income is not enough to cover living expenses, the applicant must explain how these costs are being met.

Note: Seasonal income is counted during the months worked.

DRAFT

NOTIFYING THE DEPARTMENT OF PRESUMPTIVE ELIGIBILITY DETERMINATION

Qualified hospitals are required to notify the Division of Economic Assistance of Presumptive Eligibility approvals within 2 working days. The following items should be submitted to the Department no later than 2 working days after the Presumptive Eligibility determination:

Presumptive Eligibility Medicaid Application
Presumptive Eligibility Worksheet
Notice to Applicant

If an applicant has been denied Presumptive Eligibility, the applicant has the option to have his/her application sent to the Department of Social Services for a Medicaid determination. This application, along with the notice to the applicant, should be forwarded to the Department of Social Services, Division of Economic Assistance within 2 working days. The following items should be submitted by fax no later than 2 working days after the Presumptive Eligibility denial:

Presumptive Eligibility Medicaid Application
Notice to Applicant

Qualified hospitals must submit documents by fax (605) 773-7183 to:

Department of Social Services
Division of Economic Assistance
ATTN: Presumptive Eligibility

DRAFT

APPENDIX 1: PRESUMPTIVE ELIGIBILITY WORKSHEET

Applicant Name: _____

Applicant Social Security Number: _____

Is the applicant a citizen/national? ☐ Yes ☐ No
If NO, is the applicant a qualified alien: ☐ Yes ☐ No
If YES, how is the alien qualified? _____

Is the applicant a resident of South Dakota? ☐ Yes ☐ No

Does the applicant have a Social Security Number? ☐ Yes ☐ No
If NO, has the applicant applied for a Social Security Number? ☐ Yes ☐ No

Determine Household Size:

The household size consists of the applicant, the applicant's spouse, the applicant's natural, adopted and step children under the age of 19 living in the home. In the case of a dependent child under age 19, the applicant's household consists of the applicant, the applicant's natural, adopted and step siblings under age 19 living in the home, and the applicant's parents or caretaker relatives.

Names and relationship of individuals living in the home:

Name	Relationship to Applicant
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Household Size _____

Determine Monthly Income:
Include income of all members included in the household size except children.

Amount of monthly household earned income from wages, tips or self-employment:

_____

Amount of monthly unearned income

(+) _____

Total Income (=) _____

Compare the **Total Income** to the Household Size on the appropriate chart located on the Department's website; links to the appropriate charts are located in Appendix 2. The total income must be at or below the **Monthly Dollar Amount** on the applicable chart for the **Household Size**.

- Low Income Parents and Other Caretaker Relative
- Medicaid Children under Age 19
- Pregnant Women

Eligibility Determination:

Is the applicant eligible for Presumptive Eligibility ☐ Yes ☐ No

If YES, check the program:

☐ Low Income Parents and Other Caretaker Relative
☐ Medicaid Children under Age 19
☐ Pregnant Women
☐ Former Foster Care

APPENDIX 2: INCOME GUIDELINES

Income Guidelines and additional eligibility information is available on the Department's website. Please see the following links below:

LOW INCOME PARENTS OR OTHER CARETAKER RELATIVES WITH DEPENDENT CHILDREN UNDER AGE 19

- http://dss.sd.gov/medicaleligibility/familieschildren/lifincomeguidelines.asp

MEDICAID CHILDREN UNDER AGE 19

- http://dss.sd.gov/medicalservices/chip/childwithprivate.asp

PREGNANT WOMEN

- http://dss.sd.gov/medicaleligibility/womenservices/incomeguidelineslimited.asp

FORMER FOSTER CARE INDIVIDUALS

There is no income test for this group.

The Department of Social Services, Division of Economic Assistance may be contacted to verify that the applicant was in State Foster Care.

APPENDIX 3:
APPLICANT NOTICE OF ELIGIBILITY

[HOSPITAL LETTERHEAD]

Medicaid Presumptive Eligibility Notice of Presumptive Eligibility

[Date]

[Applicant Name]
[Applicant Address]
[Applicant CITY/STATE/ZIP]

The following individual has been determined presumptively eligible to receive Medicaid coverage. **Coverage is temporary, unless you take action.** If you want to apply to continue with South Dakota Medicaid coverage after your temporary eligibility ends, a completed application must be submitted to the South Dakota Department of Social Services no later than _____ (the last day of the month following the month this notice was signed). If the application is not received by that day, eligibility will stop on that day.

If you are not found eligible for ongoing coverage your Presumptive Medicaid coverage will end effective the date that determination is made.

Individual's Name	**Individual's Social Security Number**	**Individual's Aid Category (Check one)**
Last: First: Middle:		☐ Low Income Parent/Caretaker Relative ☐ Medicaid Child Under Age 19 ☐ Pregnant Woman ☐ Former Foster Care Individual

- Pregnant Women are only covered for ambulatory prenatal care. Ambulatory prenatal care includes pregnancy-related Medicaid covered services except charges associated with inpatient care in a hospital or other medical institution and charges associated with delivery of the baby

This is not a formal ongoing Medicaid eligibility determination. See checked section below regarding your Presumptive Eligibility period:

☐ Your completed application for medical assistance has been sent to the South Dakota Department of Social Services for a formal Medicaid eligibility determination. Your presumptive eligibility period will end when the Department of Social Services makes a formal eligibility determination for Medicaid. You will receive a notice from the Department of Social Services regarding the outcome of this determination.

☐ You must submit a complete application to the Department of Social Services/Division of Economic Assistance to have a formal ongoing Medicaid eligibility determination processed. We have provided you with the application.

You may submit the application by fax to (605) 773-7183 or by mail to the following address:

Department of Social Services
Division of Economic Assistance
ATTN: Presumptive Eligibility
700 Governors Drive
Pierre, SD 57501

This Presumptive Eligibility determination was made by:

Qualified Hospital Name: _____
Designated Employee Name: _____
Phone Number: _____
Email Address: _____

APPENDIX 4:
APPLICANT NOTICE OF DENIAL

[HOSPITAL LETTERHEAD]

Medicaid Presumptive Eligibility Notice of Denial

[Date]

Applicant Name
Applicant Address
Applicant CITY/STATE/ZIP

The application for presumptive eligibility has been denied for the following applicant because:

[Applicant Name]

☐ your family income is over the allowable limit
☐ you are not a resident of South Dakota
☐ you are not a United States Citizen or Qualified Alien
☐ you did not meet a Medicaid eligibility category
☐ you have asked that your application be withdrawn
☐ you have not provided the information we requested
☐ Other, indicate reason: _____

Temporary eligibility determinations are final
There is no right to appeal a temporary eligibility decision.

You may re-apply for Medicaid benefits at any time.

- Online Applications are available at: https://apps.sd.gov/ss36snap/web/Portal/Default.aspx or https://www.healthcare.gov/
- Paper applications are available at this facility or available at your local Department of Social Services office. A list of local offices can be found at: http://dss.sd.gov/offices/
- You may also apply by phone, to do this please contact your local DSS office.

This Presumptive Eligibility determination was made by:

Qualified Hospital Name: _____
Designated Employee Name: _____
Phone Number: _____
Email Address: _____

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 if you have children together
- 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 if you do not have common children
- 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.

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

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) ☐☐☐ - ☐☐ - ☐☐☐☐

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 a. **If yes,** how many babies are expected during this pregnancy? ☐ 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 physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

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

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?** ☐ Yes ☐ No
If yes and the data is available, please complete the questions a-d. *(a-d are not required to submit application)*

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

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

13. 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

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

15. Were you in foster care at age 18 or older?** ☐ Yes ☐ No

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

17. **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 _____

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

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 18.

☐ **Not employed:** Skip to question 28.

☐ **Self-employed:** Skip to question 27.

CURRENT JOB 1:

18. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	19. Employer phone number
			( ) –

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

21. Average hours worked each WEEK**

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

22. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	23. Employer phone number
			( ) –

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

25. Average hours worked each WEEK**

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

27. **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? $

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none.** ☐

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

☐ Unemployment $ How often? _____

☐ Pension $ 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? _____

29. **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 27b).

☐ Alimony paid $ How often? _____

☐ Student loan interest $ How often? _____

☐ Other deductions Type: _____ $ How often? _____

30. **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.

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

STEP 2: PERSON 2

If you have more than six people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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) ☐☐☐ - ☐☐ - ☐☐☐☐

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 PERSON 2 doesn'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 a. **If yes,** how many babies are expected during this pregnancy? ☐ Due date: _____

9. **Does PERSON 2 need health coverage?****
(Even if PERSON 2 has 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. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

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

12. **If person 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?** ☐ Yes ☐ No

If yes and the data is available, please complete the questions a-d. (a-d are not required to submit application)

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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

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

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

15. Was PERSON 2 in foster care at age 18 or older?** ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ 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.

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

STEP 2: PERSON 2

Current job & income information**

☐ **Employed:** If PERSON 2 is currently employed, tell us about his or her income. Start with question 20.

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

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

CURRENT JOB 1:

20. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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, attach another sheet of paper.)

24. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 PERSON 2 is self-employed, answer the following questions:****

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none.** ☐

NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$	How often?	☐ Alimony received	$	How often?
☐ Pension	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Net rental/royalty	$	How often?
☐ Retirement accounts	$	How often?	☐ Other income Type:	$	How often?

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets 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?	☐ Other deductions Type:	$	How often?
☐ Student loan interest	$	How often?			

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, skip to the next person.****

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

STEP 2: PERSON 3

If you have more than six people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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) ☐☐☐ - ☐☐ - ☐☐☐☐

6. Does **PERSON 3** live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 3 doesn'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 3 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

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

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

c. Will PERSON 3 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 3 related to the tax filer? _____

8. Is PERSON 3 pregnant?** ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Due date: _____

9. **Does PERSON 3 need health coverage?****
(Even if PERSON 3 has 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. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 3 a U.S. citizen or U.S. national?** ☐ Yes ☐ No

12. **If person 3 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?** ☐ Yes ☐ No
If yes and the data is available, please complete the questions a-d. (a-d are not required to submit application)

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 3, or PERSON 3's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

14. Does PERSON 3 live with at least one child under the age of 19, and is PERSON 3 the main person taking care of this child?** ☐ Yes ☐ No

15. Was PERSON 3 in foster care at age 18 or older?** ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 22 or younger:

16. Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 3 a full-time student? ☐ 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 _____

Now, tell us about any income from PERSON 3 on the back.

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

STEP 2: PERSON 3

Current job & income information**

☐ **Employed:** If PERSON 3 is currently employed, tell us about his or her income. Start with question 20.

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

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

CURRENT JOB 1:

20. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 3 has more jobs, attach another sheet of paper.)

24. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If PERSON 3 is self-employed, answer the following questions:****

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 3 get from this self-employment this month? $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 3 gets it. Check here if none.** ☐

NOTE: You don't need to tell us about PERSON 3's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$	How often?	☐ Alimony received	$	How often?
☐ Pension	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Net rental/royalty	$	How often?
☐ Retirement accounts	$	How often?	☐ Other income Type:	$	How often?

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 3 gets it. If PERSON 3 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?	☐ Other deductions Type:	$	How often?
☐ Student loan interest	$	How often?			

32. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month. If you don't expect changes to PERSON 3's monthly income, skip to the next person.****

PERSON 3's total income **this year**	PERSON 3's total income **next** year (if you think it will be different)
$	$

THANKS!

This is all we need to know about PERSON 3.

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

STEP 2: PERSON 4

If you have more than six people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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) ☐☐☐ - ☐☐ - ☐☐☐☐

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 4 doesn'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 4 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

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

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

c. Will PERSON 4 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 4 related to the tax filer? _____

8. Is PERSON 4 pregnant?** ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Due date: _____

9. **Does PERSON 4 need health coverage?****
(Even if PERSON 4 has 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. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 4 a U.S. citizen or U.S. national?** ☐ Yes ☐ No

12. **If person 4 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ** ☐ Yes ☐ No

If yes and the data is available, please complete the questions a-d. (a-d are not required to submit application)

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 4, or PERSON 4's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 4 live with at least one child under the age of 19, and is PERSON 4 the main person taking care of this child?** ☐ Yes ☐ No

15. Was PERSON 4 in foster care at age 18 or older?** ☐ Yes ☐ No

Please answer the following questions if PERSON 4 is 22 or younger:

16. Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 4 a full-time student? ☐ 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 4 on the back.

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

STEP 2: PERSON 4

Current job & income information**

☐ **Employed:** If PERSON 4 is currently employed, tell us about his or her income. Start with question 20.

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

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

CURRENT JOB 1:

20. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 4 has more jobs, attach another sheet of paper.)

24. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If PERSON 4 is self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 4 get from this self-employment this month? $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 4 gets it. Check here if none.** ☐

NOTE: You don't need to tell us about PERSON 4's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____

☐ Pension $ 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? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 4 gets it. If PERSON 4 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 Type: _____ $ How often? _____

32. **YEARLY INCOME: Complete only if PERSON 4's income changes from month to month. If you don't expect changes to PERSON 4's monthly income, skip to the next person.****

PERSON 4's total income **this year**	PERSON 4's total income **next** year (if you think it will be different)
$	$

THANKS!

This is all we need to know about PERSON 4.

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

STEP 2: PERSON 5

If you have more than six people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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) ☐☐☐ - ☐☐ - ☐☐☐☐

6. Does PERSON 5 live at the same address as you?** ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 5 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 5 doesn'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 5 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 5 claim any dependents on his or her tax return? ☐ Yes ☐ No

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

c. Will PERSON 5 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 5 related to the tax filer? _____

8. Is PERSON 5 pregnant?** ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Due date: _____

9. **Does PERSON 5 need health coverage?****
(Even if PERSON 5 has 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. Does PERSON 5 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 5 a U.S. citizen or U.S. national?** ☐ Yes ☐ No

12. **If person 5 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ** ☐ Yes ☐ No

If yes and the data is available, please complete the questions a-d. (a-d are not required to submit application)

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Has PERSON 5 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 5, or PERSON 5's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 5 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 5 live with at least one child under the age of 19, and is PERSON 5 the main person taking care of this child?** ☐ Yes ☐ No

15. Was PERSON 5 in foster care at age 18 or older?** ☐ Yes ☐ No

Please answer the following questions if PERSON 5 is 22 or younger:

16. Did PERSON 5 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 5 a full-time student? ☐ 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 5 on the back.

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

STEP 2: PERSON 5

Current job & income information**

☐ **Employed:** If PERSON 5 is currently employed, tell us about his or her income. Start with question 20.

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

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

CURRENT JOB 1:

20. Employer name**

a. Employer address

b. City | c. State | d. ZIP code | 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 5 has more jobs, attach another sheet of paper.)

24. Employer name**

a. Employer address

b. City | c. State | d. ZIP code | 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 5:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If PERSON 5 is self-employed, answer the following questions:****

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 5 get from this self-employment this month? $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 5 gets it. Check here if none.** ☐

NOTE: You don't need to tell us about PERSON 5's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pension $ 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? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 5 gets it. If PERSON 5 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 Type: _____ $ How often? _____

32. **YEARLY INCOME: Complete only if PERSON 5's income changes from month to month. If you don't expect changes to PERSON 5's monthly income, skip to the next person.** **

PERSON 5's total income **this year** $

PERSON 5's total income **next** year (if you think it will be different) $

THANKS!

This is all we need to know about PERSON 5.

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

STEP 2: PERSON 6

If you have more than six people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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) ☐☐☐ - ☐☐ - ☐☐☐☐

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

If no, list address: _____

7. **Does PERSON 6 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 6 doesn'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 6 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 6 claim any dependents on his or her tax return? ☐ Yes ☐ No

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

c. Will PERSON 6 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 6 related to the tax filer? _____

8. Is PERSON 6 pregnant?** ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Due date: _____

9. **Does PERSON 6 need health coverage?****
(Even if PERSON 6 has 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. Does PERSON 6 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 6 a U.S. citizen or U.S. national?** ☐ Yes ☐ No

12. **If person 6 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ** ☐ Yes ☐ No

If yes and the data is available, please complete the questions a-d. (a-d are not required to submit application)

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Has PERSON 6 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 6, or PERSON 6's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 6 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 6 live with at least one child under the age of 19, and is PERSON 6 the main person taking care of this child?** ☐ Yes ☐ No

15. Was PERSON 6 in foster care at age 18 or older?** ☐ Yes ☐ No

Please answer the following questions if PERSON 6 is 22 or younger:

16. Did PERSON 6 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 6 a full-time student? ☐ 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 6 on the back.

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

STEP 2: PERSON 6

Current job & income information**

☐ **Employed:** If PERSON 6 is currently employed, tell us about his or her income. Start with question 20.

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

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

CURRENT JOB 1:

20. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 6 has more jobs, attach another sheet of paper.)

24. Employer name**

a. Employer address

b. City	c. State	d. ZIP code	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 6:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If PERSON 6 is self-employed, answer the following questions:****

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 6 get from this self-employment this month? $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 6 gets it. Check here if none.** ☐

NOTE: You don't need to tell us about PERSON 6's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pension $ 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? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 6 gets it. If PERSON 6 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 Type: _____ $ How often? _____

32. **YEARLY INCOME: Complete only if PERSON 6's income changes from month to month. If you don't expect changes to PERSON 6's monthly income, skip to the next person.****

PERSON 6's total income **this year**	PERSON 6's total income **next** year (if you think it will be different)
$	$

THANKS!

This is all we need to know about PERSON 6.

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

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?**

☐ **NO. If no,** skip to Step 4.

☐ **YES. If yes,** please complete Appendix B to make sure you receive all benefits that are available.

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?****

☐ **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 _____

☐ TRICARE (Don't check if you have Direct Care or Line of Duty)

_____

☐ VA health care program _____

☐ 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.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Department of Social Service if anything changes (and is different than) what I wrote on this application. I can call my local office to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by writing DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501 or call (605) 773-3305.
- I know that my information on this form will be used only to determine eligibility for health coverage and will be kept private as required by law.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, US Department of Labor, other governmental agencies, private financial institutions and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

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

STEP 5 (Continued)

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 the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice and 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.

If anyone on this application is eligible for Medicaid

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home?
  ☐ Yes ☐ No
- If yes, I know I'll 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 Medicaid and I may not have to cooperate.

What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

If you wish to appeal our decision to 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.

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've provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 6

Mail, fax or take your completed application to a local Department of Social Services office.

A list of local offices can be found at http://dss.sd.gov/offices/ .

If you want to register to vote, you can complete a voter registration form at usa.gov.

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

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

c. 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).

NEED HELP WITH YOUR APPLICATION? If you need help completing this form or bringing it to the local Department of Social Services office, please call your local Department of Social Services office and ask for help. A list of local offices can be found at http://dss.sd.gov/offices/

Health Insurance Marketplace

EMPLOYER COVERAGE TOOL

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

EMPLOYEE information

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

1. Employee name (First, Middle, Last)	2. Employee 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** (Go to question 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) (Go to next question)

☐ **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 this 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 (Go to next question)

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 this 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 that meets the minimum value standard* and is available to the employee only. (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

c. 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).

NEED HELP WITH YOUR APPLICATION? If you need help completing this form or bringing it to the local Department of Social Services office, please call your local Department of Social Services office and ask for help. A list of local offices can be found at http://dss.sd.gov/offices/

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? _____

NEED HELP WITH YOUR APPLICATION? If you need help completing this form or bringing it to the local Department of Social Services office, please call your local Department of Social Services office and ask for help. A list of local offices can be found at http://dss.sd.gov/offices/

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 related to this application.

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) | 5. Agents/Brokers only: NPN number

NEED HELP WITH YOUR APPLICATION? If you need help completing this form or bringing it to the local Department of Social Services office, please call your local Department of Social Services office and ask for help. A list of local offices can be found at http://dss.sd.gov/offices/