State of South Dakota – Department of Social Services

Application for Resource Assessment, Long Term Care or Related Medical Assistance

Fill in the circles like this ○ - ●

Section A

You and/or Your Spouse

Try to fill out as much of the form as you can.

We need facts about you and your spouse. We need to know about your spouse even if your spouse does not want benefits.

If you are not married, do not fill in the sections marked spouse.

Please use dark ink. Please print. If you need more room, add pages	Applicant The person applying for benefits	Spouse
What benefits are you applying for?	☐ Assisted Living ☐ In Home Services ☐ Family Support Waiver ☐ Nursing Facility ☐ Hospitalization ☐ Group Home ☐ Resource Assessment ☐ Other/Unknown	☐ Assisted Living ☐ In Home Services ☐ Family Support Waiver ☐ Nursing Facility ☐ Hospitalization ☐ Group Home ☐ Resource Assessment ☐ Other/Unknown
First Name		
Middle Name		
Last Name		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number		
Birth Date (MM, DD, YYYY)		
Marriage Status (mark one)	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	If divorced, list date:
If deceased, date (mm, dd, yyyy)		
Current Address		
City		
State, ZIP		
Phone Number		
Mailing Address		
City		
State, ZIP		
County		

Section A

You and/or Your Spouse

(continued)

	Applicant		Spouse	
E-mail	_____		_____	
Live in South Dakota?	☐ Yes	☐ No	☐ Yes	☐ No
Plan to stay in South Dakota?	☐ Yes	☐ No	☐ Yes	☐ No
Hispanic or Latino? (optional)	☐ Yes	☐ No	☐ Yes	☐ No
Race (optional)	☐ Native American or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ White		☐ Native American or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ White	
If Native American, Have you received or are you eligible for a service from Indian Health Services (IHS), Urban Indian Health or other tribal healthcare?	☐ Yes	☐ No	☐ Yes	☐ No

Section B

Citizenship

Provide citizenship documentation if not a US citizen.

	Applicant		Spouse	
Are you a U.S. Citizen? If yes, go to Section C	☐ Yes ☐ No If no, give facts below		☐ Yes ☐ No If no, give facts below	
Are you a refugee or legally admitted immigrant?	☐ Yes	☐ No	☐ Yes	☐ No
Date you entered the U.S. mm/dd/yyyy:				
Are you registered with the U.S. Citizenship and Immigration Services?	☐ Yes	☐ No	☐ Yes	☐ No
	_____ If yes, document type _____ Alien, I-94, or passport number		_____ If yes, document type _____ Alien, I-94, or passport number	

Section C

People Helping You

Person helping with legal matters - Please provide a copy of documentation.

Do you have someone helping with legal or financial matters? ☐ Yes ☐ No

If yes, tell us about that person: ☐ Guardian ☐ Power of Attorney

Name

Address

City State Zip Code

Phone E-mail

Person helping you fill out this form

Is someone helping you or your spouse fill out this form? ☐ Yes ☐ No

Name

Relationship or Organization

Phone E-mail

Person who can be contacted for information

If you want, you can give someone the right to act for you. That person can:

- **Give and get facts for this application**
- **Take any action needed for the application process**

Take any action needed for you to get benefits. This includes reporting changes.

Name Relationship to you

Address

City State Zip Code

Phone E-mail

If you would like DSS to release forms or official notices to this individual or anyone else, please complete the authorization on page 18.

Section D

Your Home or Where You Live

Where do you live?	
Applicant	**Spouse**
☐ Nursing home	☐ Nursing home
☐ Assisted living center	☐ Assisted living center
☐ Group home for people with intellectual or developmental disabilities (ICF/IID)	☐ Group home for people with intellectual or developmental disabilities (ICF/IID)
☐ Your own home	☐ Your own home
☐ With someone else in their home	☐ With someone else in their home
☐ House paid for by someone else	☐ House paid for by someone else
☐ Other	☐ Other

Applicant

If you live in a facility, or expect to admit to a facility, please fill out below:

Name of facility and location: _____

Admission Date (mm, dd, yyyy) :

Discharge date (mm, dd, yyyy):

Were you in the hospital before moving to a facility or getting services in your home? ☐ Yes ☐ No

If yes, the date you entered the hospital or started getting services in your home.

Date (mm, dd, yyyy):

Have you been private paying for your care? ☐ Yes ☐ No

If yes, for how many months?

_____
Number of Months

Do you have any unpaid medical bills from the last 3 months? ☐ Yes ☐ No

If yes, please provide a copy of the bills.

What month are you requesting assistance from Medicaid to start?

_____
Month

_____
Name of your primary care physician and location

Section E

Resources/ Assets

Reminder:

Answer the questions for you and/or your spouse.

Please provide the most recent 3 months of bank statements

If you need more room, copy the pages.

Resources/Assets – Complete questions below for yourself and your spouse. Include all your resources/assets, and those owned by your spouse or owned jointly with anyone.

Checking account owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Account 2

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Savings account owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Account 2

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Nursing home account owned by you or your spouse? ☐ Yes ☐ No

Name of the place that keeps this fund for you _____ Value _____

City _____ State _____ Zip _____ Phone _____

Section E

Resources/ Assets (continued)

Reminder: Answer the questions for you and/or your spouse.

If you need more room, copy the pages.

Employee payroll debit card or Direct Express Federal Benefits cards owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Certificates of deposit (CD's), savings bonds or money market accounts owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Account 2

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Health savings accounts established through a bank, credit union, insurance company or employer owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Section E

Resources/ Assets (continued)

Reminder:

Answer the questions for you and/or your spouse.

Please read annuity disclosure information and information concerning when the state shall be named beneficiary of an annuity provided on page 19.

Stocks or mutual funds owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Account 2

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Retirement, pension funds, Keogh, 401Ks or IRAs owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Account 2

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Annuity owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Section E

Resources/ Assets (continued)

Any other account owned by you or your spouse? ☐ Yes ☐ No

Account 1

Account Number _____ Names on account _____

Bank or company name _____ Value _____

City _____ State _____ Zip _____ Phone _____

Reminder:

Answer the questions for you and/or your spouse.

Cash on hand? ☐ Yes ☐ No If yes, how much cash: _____

Life Insurance owned by you or your spouse? ☐ Yes ☐ No

Name of insured person (first, middle, last) _____ Name of policy owner _____

Policy Number _____ Insurance Company _____

Company Address _____ City _____ State _____ Zip Code _____

Phone: _____

Face Value/Cash Value _____ Type of Policy _____ ☐ Monthly ☐ Quarterly ☐ Yearly How often is the premium paid?

Name of insured person (first, middle, last) _____ Name of policy owner _____

Policy Number _____ Insurance Company _____

Company Address _____ City _____ State _____ Zip Code _____

Phone: _____

Face Value/Cash Value _____ Type of Policy _____ ☐ Monthly ☐ Quarterly ☐ Yearly How often is the premium paid?

Section E

Resources/ Assets (continued)

Do you or your spouse have any financial arrangements such as contracts, insurance, or accounts designated for burial? ☐ Yes ☐ No
If yes, list below and provide a copy.

Where? (Applicant)	Date purchased (mm/dd/yy)	Value
Where? (Spouse)	Date purchased (mm/dd/yy)	Value

Are you or your spouse named in any trusts or have ownership in any trusts? If yes, give facts below and provide a copy of the trust. ☐ Yes ☐ No

Owner/name of trust	Values

Reminder:

Answer the questions for you and/or your spouse.

Do you or your spouse have any cars, trucks, boats, or other recreational vehicles? ☐ Yes ☐ No

Make/Model		Year	value
Owner	Amount owed	Primary use	
Make/Model		Year	Value
Owner	Amount owed	Primary use	

Do you or your spouse own a home (includes mobile)? ☐ Yes ☐ No

Address of the home	Amount owed	Value

If you are not living in your home right now, do you plan on returning to your home? ☐ Yes ☐ No

Please provide a copy of the latest real estate tax statement.

Do you have a reverse mortgage on your home? ☐ Yes ☐ No

Did you receive lump sum? ☐ Yes ☐ No If yes, how much? _____

Do you receive a monthly payment? ☐ Yes ☐ No If yes, how much? _____

Section E

Things You and Your Spouse are Paying for or Own

(continued)

Do you or your spouse own or share ownership of any other land, lots, or real estate? If yes, list property address/county below. ☐ Yes ☐ No

Address or location	Value

Do you or your spouse have a life estate or remainder interest in property? If yes, list property address/county below. ☐ Yes ☐ No

Address or location	Amount of land	Value

Provide a copy of contract.

Do you or your spouse have any promissory notes, mortgage notes or a contract for deed? If yes, provide a copy of the contract. ☐ Yes ☐ No

The terms are: ☐ Negotiable ☐ Non-negotiable Value: _____

Do you or your spouse have mineral, oil, gas, timber, wind, or surface rights? If yes, please complete below: ☐ Yes ☐ No

Owner	Address or location	Type	Value

Do you or your spouse own any business equipment, machinery, livestock, antiques, collections other than household furnishings? ☐ Yes ☐ No

Item	Value

Do you or your spouse hold any interest in a partnership or corporation? If yes, list below: ☐ Yes ☐ No

Name of partnership/corporation

If this is a resource assessment only, you can skip the rest of the questions. Just go to page 22 and sign the form.

Section F

Tell Us About Your Household

Dependents

Tell us about children, or other dependents, living with you.

Person 1

Name _____ Relationship _____ Is this person disabled? ☐ Yes ☐ No

Birth date (mm/dd/yyyy) _____ Social Security Number _____

Income (gross) _____ Source _____ Amount _____ Frequency _____

Person 2

Name _____ Relationship _____ Is this person disabled? ☐ Yes ☐ No

Birth date (mm/dd/yyyy) _____ Social Security Number _____

Income (gross) _____ Source _____ Amount _____ Frequency _____

Person 3

Name _____ Relationship _____ Is this person disabled? ☐ Yes ☐ No

Birth date (mm/dd/yyyy) _____ Social Security Number _____

Income (gross) _____ Source _____ Amount _____ Frequency _____

Housing costs

Do you or your spouse have shelter costs? ☐ Yes ☐ No

If yes, tell us the costs you have for the home you live in. All shelter costs must be verified. Please attach proof of cost (mortgage/rent payment and tax, utility and insurance bills).

	Applicant pays:	Spouse pays:	Other – List Name _____
Rent or house payment			
Tax on home			
Utilities			
Home insurance			

Section G

Medical Facts

Medicare

Do you or your spouse have Medicare? If yes, please complete below: ☐ Yes ☐ No

	Applicant	Spouse
If yes, mark the type	☐ Part A ☐ Part B ☐ Part D	☐ Part A ☐ Part B ☐ Part D
Part D Plan Name		
Start date : (mm/dd/yy)		
Claim number (HICN)		
Medicare premium (monthly cost)?		

LTC Insurance

Do you or your spouse have long term care insurance? ☐ Yes ☐ No

Is this a Partnership Plan? ☐ Yes ☐ No ☐ Unsure

Name of insured person (first, middle, last) _____ Name of policy holder _____

Policy Number _____ Insurance Company _____

Company Address _____ City _____ State _____ Zip Code _____

Phone: _____

How much is the premium? _____ Who pays the premium? _____ ☐ Monthly ☐ Quarterly ☐ Yearly How often is the premium paid?

Reminder: Provide a copy of cards.

Health Insurance: Do you or your spouse have private health insurance or Medicare supplemental insurance? ☐ Yes ☐ No

Name of insured person (first, middle, last) _____ Name of policy holder _____

Insurance company _____ Insurance company address _____

Policy number _____ Coverage start date _____ Coverage end date _____ Type of coverage _____

How much is the premium? _____ Who pays the premium? _____ ☐ Monthly ☐ Quarterly ☐ Yearly How often is the premium paid?

Do you get this insurance through a job you had or have? ☐ Yes ☐ No

If yes, list employer's name _____

Section H

Money or Property You or Your Spouse Sold, Traded, or Gave Away

In the last 60 months have you, your spouse, or anyone on behalf of you or your spouse (i.e. family members, power of attorney, guardian, or conservator), transferred, given away, gifted, loaned, sold or deeded anything of value, such as money, land, buildings, home property, etc.? ☐ Yes ☐ No

What did you sell, trade, or give away?	Value	What did you get in return?
Who did you sell, trade, or give it to?		Date sold/given away (mm/dd/yy)

What did you sell, trade, or give away?	Value	What did you get in return?
Who did you sell, trade, or give it to?		Date sold/given away (mm/dd/yy)

Did you give up the right to get any money (including income) or an inheritance in the last 60 months? ☐ Yes ☐ No If yes, explain:

In the last 60 months have you, your spouse, or anyone on behalf of you or your spouse (i.e. family members, power of attorney, guardian, or conservator) established a joint ownership in any real property owned by either you or your spouse? ☐ Yes ☐ No

Name of Joint Owner	Type of Property
Address of Joint Owner	Date (mm/dd/yy)

Name of Joint Owner	Type of Property
Address of Joint Owner	Date (mm/dd/yy)

Section H

Money or Property You or Your Spouse Sold, Traded, or Gave Away

(continued)

In the last 60 months, has a joint owner taken possession of their share in any of your or your spouse's asset such as money, savings accounts, checking accounts, certificates of deposits, bonds, stocks, or anything else of value? ☐ Yes ☐ No

Name of Joint Owner	Type of Property
Address of Joint Owner	Date (mm/dd/yy)
Name of Joint Owner	Type of Property
Address of Joint Owner	Date (mm/dd/yy)

In the last 60 months were any of your or your spouse's funds or property placed into trust for you, your spouse, or anyone else? ☐ Yes ☐ No

Name of Trustee	Type of Property
Address of Trustee	Date placed in trust (mm/dd/yy)
Name of Trustee	Type of Property
Address of Trustee	Date placed in trust (mm/dd/yy)

Is any of your income paid directly into a trust? ☐ Yes ☐ No

Name of Trustee	Source of Income
Address of Trustee	Date trust established (mm/dd/yy)
Name of Trustee	Source of Income
Address of Trustee	Date trust established (mm/dd/yy)

Section I

Money Coming into Your Home

(income)

Save Time: Veterans & veteran's widows must apply for benefits. Contact your local VA office.

Medicaid applicants must apply for all benefits they may be entitled to receive.

Income	
Applicant	**Spouse**
Do you or your spouse get Social Security?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
Do you or your spouse get Supplemental Security Income?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
Are you or your spouse a veteran?	
☐ Yes ☐ No	☐ Yes ☐ No
Do you or your spouse get veteran's benefits?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
_____ Claim number	_____ Claim number
Do you or your spouse get railroad retirement benefits?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
_____ Claim number	_____ Claim number
Do you or your spouse get civil service retirement payments?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
_____ Claim number	_____ Claim number
Do you or your spouse get any other retirement or pension payments?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
_____ Source	_____ Source
_____ What is the claim number?	_____ What is the claim number?

Section I

Money Coming into Your Home

Applicant	Spouse
Do you or your spouse get any payments from annuities?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the monthly amount?	_____ If yes, what is the monthly amount?
_____ Company	_____ Company
_____ What is the claim number?	_____ What is the claim number?
Do you or your spouse get dividends from stock, bonds or insurance?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the amount?	_____ If yes, what is the amount?
_____ How often?	_____ How often?
_____ Source	_____ Source
Do you or your spouse get rental income?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the amount?	_____ If yes, what is the amount?
_____ How often?	_____ How often?
Do you or your spouse expect to get money from: - a lawsuit – a personal injury settlement – an accident liability claim – an inheritance?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, please list the name and phone number of a person who can tell us about the settlement.	
Do you or your spouse get money from leases or royalties from oil, gas, mineral, wind, timber or surface rights?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the amount?	_____ If yes, what is the amount?
_____ How often?	_____ How often?
Are you self-employed?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ Gross income amount	_____ Gross income amount

If self-employed, please provide your most current income tax forms.

Section I

Money Coming into Your Home

(continued)

Applicant	Spouse
Do you or your spouse get money from a job?	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what is the amount before taxes?	_____ If yes, what is the amount before taxes?
_____ How often?	_____ How often?
_____ Name of Employer	_____ Name of Employer
Do you or your spouse get the following types of money from anyone else or anywhere else? • cash • gifts • payments you get for loaning money to someone else • bills paid for you • child support • training • alimony • income from Life Estate • other	
☐ Yes ☐ No	☐ Yes ☐ No
_____ If yes, what type of money do you get?	_____ If yes, what type of money do you get?
_____ If yes, who do you get the money from and why?	_____ If yes, who do you get the money from and why?
_____ If yes, what is the amount you get?	_____ If yes, what is the amount you get?

Section J

Programs You've Applied For

Money you or your spouse might get from other programs

Are you waiting for an answer on an application for one of the programs listed below?
Mark any that apply

Applicant	Spouse
☐ Social Security	☐ Social Security
☐ Supplemental Security Income (SSI)	☐ Supplemental Security Income (SSI)
☐ Veteran's benefits	☐ Veterans' benefits
☐ Other benefits _____	☐ Other benefits _____

Section K

Authorization to Release Information is optional. This is used when you want us to communicate with others about your application or case.

Signing up to vote - Optional

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

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

☐ **Yes** ☐ **No**

If you checked yes, the Department of Social Services will send you a voter registration form. Return the completed registration card to the County Auditor in your county of residence or to your local Department of Social Services office, Department of Human Services office, WIC office or military recruitment office. **The deadline for registration is 15 days before any election.**

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

Please note that the information and office to which application was made will remain confidential and be used for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private.

If you believe that someone has interfered with your right to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537

EA Authorization to Release Information

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

Individual/Facility and Name of Facility Person to Receive Information: _____

Address: _____

Phone Number: _____ Fax Number: _____

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

I allow DSS-EA to release only the following checked information to the above strategy: (check all that apply)

☐ Copy of Application/Renewal Form Dated: Month(s) ____ Year(s) ____ ☐ Address on File

☐ Copy of Notices from DSS-EA Relating to Application/Renewal Form Dated: Month(s) _____ Year(s) _____

☐ Copy of Verification Checklist Form (EA-264) Dated: Month(s) _____ Year(s) _____

Purpose of this disclosure: _____.

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

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

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

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

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

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

Section L

Statement of Understanding

Assignment of Medical Support, Insurance Proceeds

As application for and acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation of any rights to medical support, insurance proceeds, or both that the applicant or recipient may have. Any rights or amounts so assigned or subrogated shall be applied against the cost of the applicant's or recipient's care.

Disclosure of Annuities and State to be named as Remainder Beneficiary

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6012 requires individuals applying for long-term care medical assistance and an individual whose eligibility is being reviewed for purposes of determining whether the individual continues to be eligible for long-term care assistance to disclose the description of any interest the individual or the individual's spouse has in an annuity or similar financial instrument. Failure to disclose this information results in ineligibility for assistance. In addition, a recipient of long term care assistance must name the department as a preferred remained beneficiary of any interest the individual or individual's spouse has in an annuity or similar financial instrument purchased and owned after February 7, 2006.

Note: The annuity will also be considered a resource.

Privacy Act Statement

Federal and State Law and Regulations limit the use and disclosure of confidential information concerning applicants and recipients of economic and medical assistance programs to purposes directly related to the administration of those programs. When you apply for assistance, you will be asked to provide your Social Security Number (SSN) on the application form. Title 42 of the Code of Federal Regulations Part 435.910(a), requires the furnishing of a SSN as a condition of eligibility for Medicaid. The Department uses your number in its computer processing of eligibility determination, welfare fraud investigation and audits. SSNs are also used to verify income information through agencies such as the IRS, Department of Labor, and Social Security Administration, etc., to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in benefits easier to implement and to determine the accuracy and reliability of information given to the department by applicant for and recipients of assistance.

Civil Rights Guarantee

The provisions of the Civil Rights Act of 1964, as amended, also apply to your case and department representatives shall not, on the grounds of race, color, creed, religion, sex, disability, ancestry, or national origin, exclude you from participation in, deny the benefits of, or otherwise subject you to discrimination under any program or activity administered by the department. Any person who feels that their civil rights have been violated may request a fair hearing. You may also file a complaint by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or by calling (605) 773-3305

Verifications

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials will verify information given on this form to determine if it is correct. A department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your Medical case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

Medicaid Estate Recovery Program

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased medical assistance recipients who were permanently institutionalized or who were at least 55 years of age and for whom the Department made a payment for nursing facility services, intermediate care facility services for individuals with intellectual disabilities, other medical institutional services, home and community based services, hospital services, and prescription drug services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be liable for recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended on behalf of the recipient. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by a recipient who has received a benefit from the Department of Social Services for the services of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach.

Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the nursing home or other facility if the resident was receiving medical assistance from the Department at the time of death. Information in regards to the Estate Recovery Program, can be located at **http://dss.sd.gov/keyresources/benefitfraud/estate.aspx.**

Language Assistance

1. Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).
2. Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).
3. 繁體中文 (Chinese) - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-305-9673（TTY：711）
4. ကညီ(Karen) - ဟ်သူဉ်ဟ်သး-နမ့်ကတိၤ ကညီကျိာ်အဃိ, နမၤနှ့် ကျိာ်အတ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-800-305-9673 (TTY: 711).
5. Tiếng Việt (Vietnamese) - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-305-9673 (TTY: 711).
6. नेपाली (Nepali) - यान ˜दनुहोस:ो तपाइ˜ले नेपाल˜ बो नह छ भन तपाइ˜को ˜ि◌न त भाषा सहायता सवाह ˜नःश क पमा उपल ध छ । फोन गनुहोसर् ो1-800-305-9673 (˜ट˜टवाइ: 711)
7. Srpsko-hrvatski (Serbo-Croatian) - OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-305-9673 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
8. አማርኛ (Amharic) - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-305-9673 (መስማት ለተሳናቸው: 711).
9. Sudanic Adamawa (Fulfulde) MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-305-9673 (TTY: 711).
10. Tagalog (Tagalog – Filipino) - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-305-9673 (TTY: 711).
11. 한국어 (Korean) - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수있습니다. 1-800-305-9673 (TTY: 711)번으로 전화해 주십시오.
12. Русский (Russian) - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-305-9673 (телетайп: 711).
13. Cushite Oroomiffa (Oromo) - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-305-9673 (TTY: 711).
14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 800-305-9673 (TTY: 711).
15. Français (French) - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-305-9673 (ATS : 711).

Notice of Nondiscrimination

As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Social Services directly or through a contractor or any other entity with which the Department of Social Services arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Social Services directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence against Women.

The Department of Social Services:

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

If you need these services, contact your local DSS office.

If you believe that DSS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a discrimination complaint or grievance with: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. Phone: (605) 773-3305, Fax: (605) 773-7223, DSSInfo@state.sd.us. You can file a discrimination complaint or grievance in person or by mail, fax, or email. If you need help filing a discrimination complaint or grievance, the Discrimination Coordinator, Director of DSS Division of Legal Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, and 28 CFR Part 35, the Omnibus Crime Control and Safe Streets Act of 1968, Title IX of the Education Amendments of 1972, Equal Treatment for Faith-based Religions at 28 CFR Part 38, the Violence Against Women Reauthorization Act of 2013, and Section 1557 of the Affordable Care Act.

Did you...

1. **Include the "Items we requested" listed throughout the application.**
2. **Sign and date below.**

By signing below, I agree:

- I understand that any false statements which I may make and any failure on my part to report any chance in circumstance which would affect my eligibility for payment from programs administered by the South Dakota Department of Social Services constitutes a crime and that I could be prosecuted under South Dakota criminal laws.
- I agree to provide information upon request from the Department of Social Services concerning any asset or estate which may be subject to recovery, estate recovery, or medical assistance liens by the State of South Dakota.

Applicant should sign the application unless incapacitated or represented by a legal (court appointed) guardian. A representative, who can make health related decisions, may sign the application on behalf of the incapacitated or deceased applicant. The applicant's mark should be witnessed by a person familiar with the applicant.

Authorization to Furnish and Release Information

I hereby authorize any person, agency, or institutions to supply information requested by the Department of Social Services concerning me or my family, and allow inspection and reproduction of the records in his or their possession pertaining to me or my family by any duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

This authorization is given only in connection with its use by the Department in the administration of its programs and for no other purpose. It shall continue in effect until such time as I state in writing that it is no longer valid.

I therewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

Applicant		Spouse	
Sign above	**Date**	**Sign above**	**Date**
_____		_____	
Print name		**Print name**	

If you are a parent, guardian, authorized representative, court appointed administrator, executor, or have power of attorney for this person, sign below:

_____	
Sign here (must provide proof)	**Date**
Sign here if you are a witness (only needed if anyone above signed with an "X" or other mark)	**Date**
Printed name of witness	