Fax

Date: _____

Number of pages: _____
(including cover sheet)

To	**From**
Name:	Name:
Company:	S.C. Department of Public Health
Department:	Program:
Fax:	Fax:
Phone:	Phone:

Subject/Comments

Confidentiality Notice
This transmission is intended only for the use of the individual or entity to which it is addressed and may contain information which is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, distribution, or copying of this information is strictly prohibited. If you received this transmission in error, please notify the sender immediately by calling the above telephone number.

00003-ENG-CR 07/24

DPH Application Date: _____

STEP 1 Tell us about your family.

Number in family: _____

Who do you need to include on this application?

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

You DON'T have to include: Your unmarried partner who doesn't need health coverage; Your unmarried partner's children; Your parents who live with you, but file their own tax return (if you're over 21); Other adult relatives who file their own tax return.

Some Medicaid programs that cover specific services require additional information to determine eligibility. By completing this section, we will be able to ask you for information most relevant to your needs. If anyone applying for coverage meets the following criteria, please check all boxes that apply. **Even if you or your household members do not meet any of these criteria, you may still qualify for Medicaid. If none apply, do not check anything; we will evaluate you for all available coverage types.**

- ☐ Need to live in a medical facility or nursing home or need nursing services at home
- ☐ Receiving treatment for one of the following:
  -Breast cancer -Cervical cancer -Atypical Breast Hyperplasia
  -Precancerous Cervical Lesion (CIN 2/3)
- ☐ SSI is ending and need to reapply for Medicaid (example: a letter citing the Pickle Amendment)
- ☐ Admitted to the U.S. as a refugee or granted asylum after arrival in the U.S.
- ☐ Have a physical or intellectual disability
- ☐ Age 65 or older
- ☐ Applying for PCSC Waiver
- ☐ Receive Medicare
- ☐ Applying for TEFRA
- ☐ Have a disability and continuing to work
- ☐ Presumptive Disability **This box for pilot use only**

Primary contact person

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

1. First name, Middle name, Last name and Suffix (Please provide full legal name)

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)? _____

Is someone helping you fill out this application?

Complete the following section if you are filling out this form on behalf of the applicant.

1. Application start date (mm/dd/yyyy)

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

3. Organization Name (if applicable)

S.C. Department of Public Health

4. ID Number (if applicable)

EIN 57-6000286

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

STEP 1: PERSON 1

Complete Step 1 for each person in your family. Start with information about yourself.

Complete Step 1 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 the instructions for more information about whom 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 (Please provide full legal name) _____

2. Relationship to you? **SELF**

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

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN) _____

a. If you don't have a SSN, have you applied for one? ☐ Yes ☐ No *If no, indicate the reason at question 15.*

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-888-842-3620.

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 dependents: _____

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

If yes, please list the tax filer: _____ How are you related to the tax filer? _____

7. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. What is your due date? _____

c. If recently pregnant, enter the date the pregnancy ended: _____

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

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

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

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

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

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

12. Do you want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

13. a. Are you a U.S. citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b. Are you a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

14. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in your document type and ID number below.

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

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Date of Entry: _____

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

15. If you have not applied for a Social Security Number, list the reason:
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid

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

a. If YES, was your household size the same during these 3 months as it is now? ☐ Yes ☐ No

b. Was your household income the same during these 3 months as it is now? ☐ Yes ☐ No

If NO, enter the total monthly income for: Last Month: $ _____ 2 Months Ago: $ _____ 3 Months Ago: $ _____

17. 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

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

19. a. Were you in foster care and enrolled in Medicaid on your 18th birthday? ☐ Yes ☐ No

b. If yes, what state did you reside in when you aged out of foster care? _____

20. Are you currently living in a foster home? ☐ Yes ☐ No

21. Are you currently living in a DJJ group home? ☐ Yes ☐ No

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STEP 1: PERSON 1 (Continue with yourself)

Ethnicity and Race: This data helps us to identify groups of people who have health concerns so we can find ways to improve their access to quality care.

22. **If Hispanic/Latino, ethnicity**
☐ Mexican ☐ Mexican–American
☐ Puerto Rican ☐ Cuban ☐ Chicano/a
☐ Other:_____
☐ I choose not to answer

23. **Race (check all that apply)**
☐ White ☐ Native Hawaiian ☐ Filipino ☐ Korean ☐ Black/African American ☐ Chinese
☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander
☐ American Indian or Alaska Native ☐ Guamanian or Chamorro ☐ Other: _____
☐ I choose not to answer

Current job & income information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 24.

☐ **Not Employed**
SKIP to question 36.

☐ **Self-Employed**
SKIP to question 35.

CURRENT JOB 1:

24. Employer name and address _____

25. Employer phone number _____

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

$ _____ 27. Average hours worked each week _____ 28. Start date _____

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

29. Employer name and address _____

30. Employer phone number _____

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

$ _____ 32. Average hours worked each week _____ 33. Start date _____

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

35. **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?)
$ _____

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

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

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

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

If PERSON 1 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.

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $ _____ How often? _____
Type: _____

38. YEARLY INCOME: Complete only if PERSON 1's income changes from month to month.

If you don't expect changes to PERSON 1's monthly income, add another person on the following pages.

PERSON 1's total income this year
$ _____

PERSON 1's total income next year (if you think it will be different)
_____

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Complete a new copy of this form for each additional person applying for Medicaid.

STEP 1: ADDITIONAL PERSON

Complete a new copy of this form for each additional person who lives with you and/or anyone on your same federal income tax return if you file one. See the instructions at the beginning of Step 1 for more information about whom 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 (Please provide full legal name)

2. Relationship to you?

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

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if this person wants health coverage and has an SSN.

a. If you don't have a SSN, have you applied for one?
☐ Yes ☐ No
If no, indicate the reason at question 16.

6. Does this person live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Does this person 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 this person file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:
b. Will this person claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list dependents:
c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the tax filer: How is person related to the tax filer?

8. Is this person pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. Due date?
c. If recently pregnant, enter the date the pregnancy ended:
d. Was this person enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. **Does this person need health coverage (Medicaid)?** *(Even if you have insurance, there might be a program with better coverage or lower costs)*
☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions. Leave the rest of this page blank.

10. Does this person have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
11. Does this person need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
12. Has this person been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)
13. Does this person want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
14. a. Is this person a U.S. citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No
b. Is this person a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No
15. **If this person isn't a U.S. citizen or U.S. national, does this person have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in this person's document type and ID number below.
a. Immigration document type: b. Document ID number:
c. Has this person lived in the U.S. since 1996? ☐ Yes ☐ No d. Date of Entry:
e. Is this person, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
16. If this person has not applied for a Social Security Number, list the reasons
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid
17. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was this person's household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was this person's household income the same during these 3 months as it is now? ☐ Yes ☐ No
If NO, enter the total monthly income for: Last Month: $ 2 Months Ago: $ 3 Months Ago: $
18. Does this person live with at least one child under 19, and is This person the main person taking care of this child? ☐ Yes ☐ No
19. Is this person a full-time student? ☐ Yes ☐ No
20. a. Was this person in foster care and enrolled in Medicaid on their 18th birthday? ☐ Yes ☐ No
b. If yes, what state did they reside in when they aged out of foster care?
21. Is this person currently living in a foster home? ☐ Yes ☐ No
22. Is this person currently living in a DJJ group home? ☐ Yes ☐ No

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STEP 1: ADDITIONAL PERSON

Ethnicity and Race: This data helps us to identify groups of people who have health concerns so we can find ways to improve their access to quality care.

23. **If Hispanic/Latino, ethnicity**
☐ Mexican ☐ Mexican–American
☐ Puerto Rican ☐ Cuban ☐ Chicano/a
☐ Other:_____
☐ I choose not to answer

24. **Race (check all that apply)**
☐ White ☐ Native Hawaiian ☐ Filipino ☐ Korean ☐ Black/African American ☐ Chinese
☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander
☐ American Indian or Alaska Native ☐ Guamanian or Chamorro ☐ Other: _____
☐ I choose not to answer

Current job & income information

☐ **Employed**
If currently employed, tell us about income.
Start with question 25.

☐ **Not Employed**
SKIP to question 37.

☐ **Self-Employed**
SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address _____

26. Employer phone number _____

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

$ _____ 28. Average hours worked each week _____ 29. Start date _____

CURRENT JOB 2: (If this person has more jobs and needs more space, attach another sheet of paper)

30. Employer name and address _____

31. Employer phone number _____

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

$ _____ 33. Average hours worked each week _____ 34. Start date _____

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

36. **If self-employed, answer the following questions:**
a. Type of work _____

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

37. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often this person gets it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

38. **DEDUCTIONS:** Check all that apply, and give the amount and how often this person gets it.
If this person 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 36b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $ _____ How often? _____
Type: _____

39. **YEARLY INCOME:** **Complete only if this person's income changes from month to month.**

This person's total income this year
$ _____

This person's total income next year (if you think it will be different)
$ _____

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STEP 2 American Indian or Alaska Native (AI/AN) family member(s)

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

☐ **If NO,** skip to Step 3.

☐ **YES. If YES,** ask for and complete SCDHHS Form 3400-Appendix B (American Indian or Alaska Native Family Member).

STEP 3 Your family's health coverage

Answer these questions for anyone who needs health coverage.

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

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

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

Claim number: _____

Date Medicare coverage started: _____

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

_____

☐ VA health care programs: _____

☐ Peace Corps: _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____ Start Date: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other health insurance _____

Name of health insurance: _____

Policy number: _____ Start Date: _____

Is this a limited-time benefit plan (ex: a school accident policy)? ☐ Y ☐ N

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 4.

STEP 4

Read and Sign. Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.
4. I understand that I must cooperate fully with state and federal workers if my case is reviewed.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

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

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6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a request for such a hearing to SCDHHS in writing, by phone, in person, or I may appeal online at www.scdhhs.gov/appeals. I know that I may represent myself or be represented by someone other than myself.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

Renewal of coverage in future years

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

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

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required on DHHS Form 1282 - Authorized Representative.

By signing, I state that I have read and agree to the rights and responsibilities stated on this application. I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.

Signature _____ Date (mm/dd/yyyy) _____

Please print this form, then sign it on the line above before submitting.

STEP 5 Mail the completed application.

Mail your signed application to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

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

NEED HELP WITH YOUR APPLICATION? Visit **SCDHHS.gov** or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

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.** If YES, continue below. ☐ **NO.** If NO, stop here and go to Step 3 on the application.

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: _____

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 ☐ Monthly ☐ 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 would the employee have to pay in premiums for this plan? $ _____

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

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

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

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EMPLOYER COVERAGE TOOL

Health Coverage from Jobs

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.
Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form.
Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

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

1. Employee name (First, Middle, Last)

2. Employee Social Security number

EMPLOYER Information

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

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

☐ **YES.** If YES, continue below. ☐ **NO.** If NO, stop here and go to Step 3 on the application.

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)

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

Name: _____ Name: _____ Name: _____

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 ☐ Monthly ☐ 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 would the employee have to pay in premiums for this plan? $ _____

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

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

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

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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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 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html