Healthy Connections

South Carolina Department of Health and Human Services

Application for Medicaid Family Planning Coverage

things to know

About this program

- This application is used to apply for Family Planning services only.
- Services include a comprehensive physical examination, some preventative health screenings, and family planning services, including birth control, permanent sterilization procedures, lab work, examinations and counseling. Coverage does not include treatment for other health conditions, prescriptions that are unrelated to family planning or Sexually Transmitted Infection (STI) treatment, or emergency hospital visits.
- If you would like to apply for full Medicaid benefits, please request a DHHS Form 3400, Application for Healthy Connections (Medicaid) by calling (800) 549-0820 or apply online at **SCDHHS.gov**.
- The Affordable Care Act requires most individuals to have health insurance coverage that meets minimum essential coverage. The Family Planning program does not meet minimum essential coverage. This means you may have to pay a tax penalty if you do not have other health insurance coverage. To learn more about health insurance coverage options or to see if you qualify for an exemption, visit www.healthcare.gov or call 1-800-318-2596.

What you may need to apply

- Social Security Number (or document numbers if a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and how to get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to **SCDHHS.gov**.

What happens next?

Send your complete, signed application to the address in Step 5. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps to complete your application for Family Planning. If you have questions, call 1-888-549-0820.

Who can use this application?

- Apply even if you already have health coverage. You could be eligible for lower-cost or free coverage.
- Certain qualifying immigrants can apply. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete the Authorized Representative Form (1282), which can be downloaded at **SCDHHS.gov**.

Get help with this application

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

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

STEP 1

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.

Your Information

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

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

3. Sex: ☐ Male ☐ Female

4. 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 24.

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If you want help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-888-842-3620.

5. Home address (Leave blank if you don't have one.)

6. Apartment or suite number

7. City

8. State

9. ZIP code

10. County

11. Mailing address (if different from home address)

12. Apartment or suite number

13. City

14. State

15. ZIP code

16. County

17. Phone number

18. Other phone number

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

Email address:

20. 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.

Application start date (mm/dd/yyyy)

First name, Middle name, Last name, & Suffix

Organization Name (if applicable)

ID Number (if applicable)

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STEP 1: Cont. (Continue with information about yourself)

21. Are you incarcerated? ☐ Yes ☐ No If YES, date incarcerated: _____

22. 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

23. **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

24. 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

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

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

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

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

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:

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

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

Current income information

☐ **Employed** Start with question 28. ☐ **Not Employed** SKIP to question 34. ☐ **Self-Employed** SKIP to question 33.

CURRENT JOB 1:

28. Employer name and address

29. Employer phone number

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

31. Average hours worked each week _____ 32. Start date _____

33. **If self-employed:** a. Type of work _____ b. Expected net income this month? _____

34. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it (for example: pension or alimony income). **NOTE:** You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____ ☐ Net farming/fishing: $_____ How often? _____

☐ Pensions $ _____ How often? _____ ☐ Net rental/royalty: $_____ How often? _____

☐ Social Security $ _____ How often? _____ ☐ Other income:

☐ Retirement acc'ts $ _____ How often? _____ ☐ Type: _____ $ _____ How often? _____

☐ Alimony received $ _____ How often? _____ ☐ Type: _____ $ _____ How often? _____

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

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions: $_____ How often? _____ Type: _____

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

1. Are you 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 health coverage

Please answer these questions about your health coverage, if applicable.

Are you 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. ☐ **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

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 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. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the 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, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
6. I know that I must tell SCDHHS 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.

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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).

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. 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.

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP
Unit (if applicable)	ID Number (if applicable)		

STEP 5 Mail the completed application.

Mail your signed application to:

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

OR Fax your application to:

(888) 820-1204

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS 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 grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are 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 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