

**SOUTH DAKOTA CHILDREN'S HEALTH INSURANCE PROGRAM
(CHIP) / MEDICAL ASSISTANCE APPLICATION**

This form is used to apply for FREE health coverage for children under the age of 19. It may also be used for FREE health coverage for pregnant women and families with children. If you have questions, contact your local Social Services Office. If more space is needed, please use a separate sheet of paper and report the information as it is listed on this form. State and federal laws prohibit discrimination in all Department of Social Services' programs and activities on the basis of race, color, national origin, gender, religion, age, disability and political beliefs. (Not all prohibited bases apply to all programs.) To file a complaint of discrimination write Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501 or call (605) 773-3305.

INSTRUCTIONS:

1. Read this application form carefully and **answer each question completely.**
2. If you need help completing or understanding this form, contact the Department of Social Services in the County where you live.
3. **Provide proof of income, insurance, and daycare or child support expenses;** copies of these documents are acceptable. **Proof of identity and citizenship is also required for all individuals requesting medical assistance; original documents required.**
4. Sign and date the application form. (If two parents are in the home, both must sign)
5. Mail, Fax, or take the application form to your local Social Services Office. A determination will be made within 45 days from the date your application is received.

1. Tell us who you are and where you live:

First Name	Initial	Last Name	Maiden Name or Other Name (if any)
Street Address			Please give us a phone number where we can call you if we have questions about your application form.
Mailing Address (if different)			Home Phone: Work Phone:
Directions to reach your home if rural:			Other Phone:
City, State, Zip Code			E-Mail:

I understand that by applying for and accepting medical assistance, I assign any rights to Medical support, insurance proceeds or both that the applicant or recipient may have. I understand that information given will be matched by computer with the records of other agencies such as Social Security or Internal Revenue Services (IRS). I understand that State and Federal law provide for fine, imprisonment, or both for any person guilty of receiving assistance which he/she is not entitled to by withholding or giving false information. I understand the penalty for perjury is a fine of up to \$5000, a sentence of up to five years in prison, or both.

Sign Date ____/____/____

CONSENT TO RELEASE INFORMATION

I give my consent for any person, agency or institution to supply information to the Department of Social Services about me or my family, and to allow inspection and copying of records about me or my family by any representative of the Department. I authorize the Department to release information to providers, State, or Federal agencies. This consent is given only for use by the Department in administration of its programs. It continues until I state in writing that it is no longer valid. I release any person, agency, or institution from any legal responsibility to me or my family for supplying such information.

Sign Date ____/____/____

Sign Spouse / Other Parent in home Date ____/____/____

This box for office use only

Date Received		Case Number	
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2. Tell us who lives in the home:

Starting with the person filling out this form. *Completion of Race, Social Security Number (SSN), and citizenship is optional for persons NOT asking for CHIP/Medical assistance.

First Name	Initial	Last name	CHIP/ Medical Asst. Wanted	Date of Birth	*Race/Ethnicity (Check all that apply)	Relationship to person filling out this form (Spouse, Friend, Child, etc.)	*U.S. Citizenship	Marital Status
			☐ Yes ☐ No	____/____/____	Hispanic or Latino ☐ Yes ☐ No	SELF	☐ Yes ☐ No	☐ Married
Name at Birth (if different)			Place of Birth	☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black	☐ English ☐ Spanish ☐ Other		☐ Single	
Last Grade Completed			Social Security Number	____ - ____ - ____	Sex ☐ Male ☐ Female		☐ Divorced ☐ Widow(er)	
First Name	Initial	Last Name	☐ Yes ☐ No	____/____/____	Hispanic or Latino ☐ Yes ☐ No	Relationship	☐ Yes ☐ No	☐ Married
Name at Birth (if different)				Place of Birth	☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ English ☐ Spanish ☐ Other	☐ Single
Last Grade Completed				Social Security Number	____ - ____ - ____	Sex ☐ Male ☐ Female		☐ Divorced ☐ Widow(er)
First Name	Initial	Last Name	☐ Yes ☐ No	____/____/____	Hispanic or Latino ☐ Yes ☐ No	Relationship	☐ Yes ☐ No	☐ Married
Name at Birth (if different)				Place of Birth	☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ English ☐ Spanish ☐ Other	☐ Single
Last Grade Completed				Social Security Number	____ - ____ - ____	Sex ☐ Male ☐ Female		☐ Divorced ☐ Widow(er)
First Name	Initial	Last Name	☐ Yes ☐ No	____/____/____	Hispanic or Latino ☐ Yes ☐ No	Relationship	☐ Yes ☐ No	☐ Married
Name at Birth (if different)				Place of Birth	☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ English ☐ Spanish ☐ Other	☐ Single
Last Grade Completed				Social Security Number	____ - ____ - ____	Sex ☐ Male ☐ Female		☐ Divorced ☐ Widow(er)
First Name	Initial	Last Name	☐ Yes ☐ No	____/____/____	Hispanic or Latino ☐ Yes ☐ No	Relationship	☐ Yes ☐ No	☐ Married
Name at Birth (if different)				Place of Birth	☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ English ☐ Spanish ☐ Other	☐ Single
Last Grade Completed				Social Security Number	____ - ____ - ____	Sex ☐ Male ☐ Female		☐ Divorced ☐ Widow(er)

3. Tell us about health insurance:

 **YES** ☐ **NO** ☐ Do any of the persons wanting CHIP/medical assistance have health insurance coverage?

(ATTACH PROOF OF OTHER INSURANCE, SUCH AS AN INSURANCE CARD (FRONT & BACK) OR STATEMENT OF BENEFITS IF COVERAGE EXISTS, INCLUDE INSURANCE FROM A FOREIGN COUNTRY.)

List the person asking for CHIP/medical assistance with Insurance	Insurance Start date	End date	Name & Address of Insurance Co.	Name of Employer with Insurance (If any)	Policy/Group # Insurance Type	Name of Policy Holder
_____	____/____/____	____/____/____			# _____ ☐ Inpatient & ☐ Pharmacy Outpatient ☐ Vision ☐ Inpatient Only ☐ Dental ☐ Outpatient Only ☐ Excludes Pregnancy Coverage ☐ Other _____	If a parent, does this parent live in the home ☐ Yes ☐ No
_____	____/____/____	____/____/____				
_____	____/____/____	____/____/____				

YES ☐ **NO** ☐ Did anyone lose a job and group health insurance within past 3 months?

If yes, name of employer _____ Date insurance ended _____ / _____ / _____

YES ☐ **NO** ☐ Has anyone dropped group health insurance within the past 3 months?

If yes, list name(s) _____ Reason for dropping _____

YES ☐ **NO** ☐ Is any child asking for CHIP/medical assistance eligible to be enrolled in health insurance through a custodial parent who has State employee coverage?

YES ☐ **NO** ☐ Did anyone asking for CHIP/medical assistance receive medical care in the last 3 months?

If yes, list name(s) _____ Date of medical care (Month/Year) _____



(ATTACH PROOF OF INCOME FROM MONTH(S) WHEN MEDICAL CARE WAS RECEIVED IF WITHIN LAST 3 MONTHS)

4. Tell us:

YES ☐ **NO** ☐ Is anyone asking for pregnancy medical coverage? **If yes, list name of pregnant person(s) and expected due date**

_____/_____/_____
Name Due Date

YES ☐ **NO** ☐ If requesting pregnancy medical coverage, is there a plan for surrogacy or adoption? **(IF YES, PROVIDE ANY AGREEMENT REGARDING COVERAGE OF MEDICAL EXPENSES.)**

Please list any income for all people living in the home. For a child living with someone other than a parent, only list the child's income. For a pregnant woman 18 or older, do NOT list her parent's income.

5. Tell us about income:

 **YES** ☐ **NO** ☐ Is anyone working? If yes, please complete the following for every job. (Do not list wages of children who are under age 18 and living with a parent)

(ATTACH PROOF OF ALL CURRENT WAGES SUCH AS PAY STUBS OR A LETTER FROM YOUR EMPLOYER FOR EACH JOB FOR THE LAST 30 DAYS. ENTER GROSS PAY, NOT TAKE HOME PAY)

First	Initial	Last Name	Where do you work?	Hours per week and Wage per hour	How Often Paid	Total GROSS \$ (Include tips each month)
					☐ weekly ☐ monthly ☐ every two weeks ☐ twice a month	\$
					☐ weekly ☐ monthly ☐ every two weeks ☐ twice a month	\$
					☐ weekly ☐ monthly ☐ every two weeks ☐ twice a month	\$

YES ☐ **NO** ☐ Is anyone self-employed?

If yes, type of work _____. **You must provide the most recent completed and signed tax forms.** (Provide entire form). If you do not have tax forms, business ledgers or office records will be needed.

 **YES** ☐ **NO** ☐ Does someone get income that is not from a job? **(ATTACH PROOF OF INCOME.)** Examples of income to list are Social Security, Child Support, GA, interest income, SSI, etc.

First	Initial	Last Name	Type of Income	How Often Received	Total GROSS \$ expected this month
				☐ weekly ☐ monthly ☐ twice a month ☐ other	\$
				☐ weekly ☐ monthly ☐ twice a month ☐ other	\$
				☐ weekly ☐ monthly ☐ twice a month ☐ other	\$

6. Tell us about expenses:

YES ☐ **NO** ☐ Does anyone pay child support?

If yes, who pays _____ How much is paid each month \$ _____

 Who is child support paid to _____
(ATTACH PROOF UNLESS PAID TO SOUTH DAKOTA CHILD SUPPORT OFFICE)

YES ☐ **NO** ☐ Does anyone pay child care so they can work?

 List only the amount actually paid. Do not list the amount paid by child care assistance or some other source.
(ATTACH PROOF OF CHILD CARE PAID)

First	Name of child Initial Last Name	Amount paid	How often paid	Name of person who pays child care First Initial Last Name	Name of Daycare or babysitter
		\$	per		
		\$	per		
		\$	per		



IMPORTANT: If you are only applying for medical assistance for children, stop here.

DO NOT complete page 4 if applying for children only. Complete page 4 if applying for coverage of pregnancy or if an adult relative caring for a child is also applying for medical assistance.



IMPORTANT: Fill out this page ONLY if applying for pregnancy coverage or if an adult relative caring for a child is also applying for medical assistance.

7. Tell us about resources:

List all resources of parent(s) or other caretaker relatives of children under age 19 or woman applying for pregnancy related coverage. If married, list spouse's resources (please mark yes or no for each box below) Examples of resources are listed below.

(Use a separate line for each individual if more than one has the same type of resource.)	YES	NO	If yes, Value	Owner(s) (List all Co-owners)			Name and address of resource location	Account Number
				First	Initial	Last Name		
Cash on Hand	☐	☐	\$					
Checking Account (banks, credit unions)	☐	☐	\$					
Savings Account (bank, credit unions)	☐	☐	\$					
Certificate of Deposit (CD)	☐	☐	\$					
IRA/Keogh/401K	☐	☐	\$					
Money Market Funds	☐	☐	\$					
Stocks	☐	☐	\$					
Bonds	☐	☐	\$					
IIIM Account	☐	☐	\$					
Burial Account	☐	☐	\$					
Trust Funds	☐	☐	\$					
Contract for Deed	☐	☐	\$					
Life Estate	☐	☐	\$					
Safe Deposit Box	☐	☐	\$					
Whole Life Insurance (not Term Insurance)	☐	☐	\$					
Uniform Transfer to Minor Account	☐	☐	\$					
Savings Bonds	☐	☐	\$				Type of Bond	Issue Date
Savings Bonds	☐	☐	\$				Type of Bond	Issue Date
Other	☐	☐	\$					

Resource	YES	NO	Owner(s) (List all Co-owners)			Year, Make, & Model	Value	Amount Owed
			First	Initial	Last Name			
Car	☐	☐					\$	\$
Car	☐	☐					\$	\$
Car	☐	☐					\$	\$
Car	☐	☐					\$	\$
Truck	☐	☐					\$	\$
Truck	☐	☐					\$	\$
Boat	☐	☐					\$	\$
Snowmobile	☐	☐					\$	\$
Camper	☐	☐					\$	\$
Motorcycle	☐	☐					\$	\$
Other Vehicle	☐	☐					\$	\$
Farm Equipment	☐	☐					\$	\$
Livestock	☐	☐					\$	\$
Other	☐	☐					\$	\$

Property	YES	NO	Owner(s) (List all Co-owners)			Property Location	Value	Amount Owed
			First	Initial	Last Name			
House	☐	☐					\$	\$
Mobile Home	☐	☐					\$	\$
Land	☐	☐					\$	\$
Building	☐	☐					\$	\$
Other	☐	☐					\$	\$

7a. If you listed a house or mobile home, is this where you live?

YES ☐ NO ☐

REMEMBER TO SIGN AND DATE THE FRONT PAGE.