

South Carolina Department of Health and Human Services
Application for South Carolina Healthy Connections
Coverage for Children, Pregnant Women, and Families

Note: You only need to tell us the Social Security Number and answer the question about being a US citizen for the people for whom you are applying. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.

- Original documents to prove US citizenship and identity must be provided for all persons applying for coverage.
- If applying for someone who is not a citizen, United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, must be provided to support his/her legal entry in the US.
- If applying for Emergency Services Only for someone who is not a citizen, the applicant is not required to provide USCIS documentation or a Social Security Number.

1. Tell us about yourself (Primary Individual)

Name (First, Middle Initial, Last):		Social Security Number: (not required for emergency services)		Date of Birth:
Address where you get mail (include apartment number)		City	State	Zip Code
Home Address (if not the same as your mailing address)		City	State	Zip Code
US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you applying for yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No		Need retroactive coverage for the past three months? <input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____
Your Full Name at Birth: This helps us verify citizenship		County/State where you were born:		Your Mother's Full Name at her Birth:
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Pregnant, Due Date: _____	Are you currently attending school? <input type="checkbox"/> Yes What grade? _____ <input type="checkbox"/> No	
Do you have Health Insurance now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Company Name _____ Policy ID# _____				
Are you the parent, stepparent, or guardian of any of the children listed on the application? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What language do you use most? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:		Race	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other:	

2. Tell us about your spouse or other adult in the home who may be the parent or guardian of the children

Name (First, Middle Initial, Last):		Social Security Number: (not required for emergency services)		Date of Birth:
US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Need retroactive coverage for the past three months? <input type="checkbox"/> Yes <input type="checkbox"/> No Months Requested: _____
Full Name at Birth: This helps us verify citizenship		County/State where born:		Mother's Full Name at her Birth:
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Pregnant, Due Date: _____	Currently attending school? <input type="checkbox"/> Yes What grade? _____ <input type="checkbox"/> No	
Does this person currently have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Company Name _____ Policy ID# _____				
Is this person the parent, stepparent, or guardian of any of the children listed on the application? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Boyfriend/Girlfriend <input type="checkbox"/> Other:		Race	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Mexican <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other:	

3. Tell us about the children who live with you.

A Social Security Number is not required if applying for Emergency Services Only

	Child 1	Child 2	Child 3
Full Name (First, Middle, Last)			
US Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number			
Medicare or Social Security Claim Number			
Date of Birth of the Child			
City, County and State where the Child was born			
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
Applying for Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's Full Name at her Birth			
Put a check for all that applies	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____
Race	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other _____
Is the Child now attending school	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____
Relationship of the Child to the Primary Individual	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
Relationship of the Child to the Spouse/Other Adult in the Home	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
Does the Child get Child Support payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you pay someone for childcare for this Child while you work or attend school?	Name of Provider or Daycare Center _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No
Need retroactive coverage for the past three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____
Does the Child have Health Insurance now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes, please give us a copy of the front and back of all health insurance cards.</i>		
If the Child does not have health insurance now, did the Child have Health Insurance in the past six (6) months? (Not including Medicaid)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____

	Child 4	Child 5	Child 6
Full Name (First, Middle, Last)			
US Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number			
Medicare or Social Security Claim Number			
Date of Birth of the Child			
City, County and State where the Child was born			
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
Applying for Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's Full Name at her Birth			
Put a check for all that applies for the Child	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____
Race	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other _____
Is the Child now attending school	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____	<input type="checkbox"/> Yes School Name and grade _____ <input type="checkbox"/> No _____
Relationship of the Child to the Primary Individual	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
Relationship of the Child to the Spouse/Other Adult in the Home	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other _____
Does the Child get Child Support payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Paid by: _____ Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you pay someone for childcare for this Child while you work or attend school?	Name of Provider or Daycare Center _____ _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ _____ Phone Number: _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No
Need retroactive coverage for the past three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Which Months: _____
Does the Child have Health Insurance now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes, please give us a copy of the front and back of all health insurance cards.</i>		
If the Child does not have health insurance now, did the Child have Health Insurance in the past six (6) months? (Not including Medicaid)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please answer the following: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____ _____ _____

8. Do you pay court ordered child support for a child outside your home? (If yes, please provide proof) Yes No

Name of Child	How much do you pay?	How often do you pay this amount?

9. Do you pay someone to take care of a dependent adult while you work or attend school? Yes No

Name of Adult	Who do you pay?	How much do you pay?	How often do you pay?

IMPORTANT

Check below to tell us what you attached.

- Sending this information in with the application will help us to process your application faster.
- You must read and sign this form on the last page to complete your application.
 - Proof of Income
 - Copies of pay stubs for the **last 4 weeks for any adult person listed**; or a letter from employer that shows last 4 weeks of GROSS pay.
 - A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
 - Proof of all other income for the last 4 weeks, including child support.

NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.
 - Proof of income for the past 3 months if you have received medical services.
 - If you are self employed, the most recent income tax forms including all schedules.
 - Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
 - United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, for each non-citizen applying for full Healthy Connections. Does not apply to Emergency Services Only.
 - Original Documents of citizenship and identity for each US citizen applying for coverage. (If you have provided this information since July 1, 2006, you do not have to provide it again.)

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Healthy Connections beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a \$25 fee. I want to voluntarily apply for these services:

Yes No

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Healthy Connections Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Healthy Connections Card(s).
 - a. I know that, in accordance with the federal rules governing the Healthy Connections Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
 - b. I know that, in accordance with the federal rules governing the Healthy Connections Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medical Assistance programs, and the TANF and Food Stamp agency (Department of Social Services (DSS), in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

- c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
 - d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released in connection with the exceptions in Item 2, above.
 4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
 5. I know that the Healthy Connections Program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS 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 hospital and health insurance policies or payments received as a settlement from an accident.
 6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Healthy Connections coverage.
 7. I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

If eligibility is for my child(ren) only, I am not required to report any changes in my situation, except for change of address. If I report any other changes in my situation, it will not affect their eligibility for benefits until the next scheduled review.
 8. I know that I may request a hearing if I believe an error has been made in processing my application.
 9. I have read the Rights and Responsibilities, or they have been read to me.
 10. By signing this application, I certify that the information I have provided to DHHS is true and accurate to the best of my knowledge.
 11. I authorize the release of any information necessary to establish my family's eligibility. I authorize the copying of this signature page to be used as a release form to verify information. It shall remain valid and in force until:
 - o Revoked by me in writing;
 - o My application has been denied; or
 - o My case has been closed.

(If possible, both the Applicant and Authorized Representative should sign.)

Applicant's Signature: _____ Date: _____

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Phone Number: _____
 Address: _____ Relationship: _____

Signature of Authorized Representative: _____ Date: _____