

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

**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.
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.

I understand I have the right to request a fair hearing if my application is not acted upon within 45 days of the application. I may also request a fair hearing if I believe the Department made an incorrect decision regarding my application within 30 days from the date I receive a written notice from Medical Assistance. To request a hearing, send a signed, written request to the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre, SD 57501-2291. The request must indicate what action is being appealed.

\_\_\_\_\_  
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	<input type="text"/>	Case Number	<input type="text"/>
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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
			<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Hispanic or Latino ___ Yes ___ No	<b>SELF</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)
Name at Birth (if different)			Place of Birth	<input type="checkbox"/> Am. Ind. <input type="checkbox"/> White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Black				
Last Grade Completed			Social Security Number	____ - ____ - ____				
First Name	Initial	Last Name	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Hispanic or Latino ___ Yes ___ No	<b>Relationship</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)
Name at Birth (if different)			Place of Birth	<input type="checkbox"/> Am. Ind. <input type="checkbox"/> White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Black				
Last Grade Completed			Social Security Number	____ - ____ - ____				
First Name	Initial	Last Name	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Hispanic or Latino ___ Yes ___ No	<b>Relationship</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)
Name at Birth (if different)			Place of Birth	<input type="checkbox"/> Am. Ind. <input type="checkbox"/> White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Black				
Last Grade Completed			Social Security Number	____ - ____ - ____				
First Name	Initial	Last Name	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Hispanic or Latino ___ Yes ___ No	<b>Relationship</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)
Name at Birth (if different)			Place of Birth	<input type="checkbox"/> Am. Ind. <input type="checkbox"/> White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Black				
Last Grade Completed			Social Security Number	____ - ____ - ____				
First Name	Initial	Last Name	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Hispanic or Latino ___ Yes ___ No	<b>Relationship</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)
Name at Birth (if different)			Place of Birth	<input type="checkbox"/> Am. Ind. <input type="checkbox"/> White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Black				
Last Grade Completed			Social Security Number	____ - ____ - ____				

**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		Name & Address of Insurance Co.	Name of Employer with Insurance (if any)	Policy/Group # Insurance Type	Name of Policy Holder
	Start date	End date				
_____	____/____/____	____/____/____			# _____ <input type="checkbox"/> Inpatient & <input type="checkbox"/> Pharmacy Outpatient <input type="checkbox"/> Vision <input type="checkbox"/> Inpatient Only <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient Only <input type="checkbox"/> Excludes Pregnancy Coverage <input type="checkbox"/> Other	If a parent, does this parent live in the home <input type="checkbox"/> Yes <input type="checkbox"/> 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, number of babies expected and expected due date**

Name \_\_\_\_\_


# of Babies \_\_\_\_\_

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)
					<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month	\$
					<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month	\$
					<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> every two weeks <input type="checkbox"/> 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
				<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice a month <input type="checkbox"/> other	\$
				<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice a month <input type="checkbox"/> other	\$
				<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice a month <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Checking Account (banks, credit unions)	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Savings Account (bank, credit unions)	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Certificate of Deposit (CD)	<input type="checkbox"/>	<input type="checkbox"/>	\$					
IRA/Keogh/401K	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Money Market Funds	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Stocks	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Bonds	<input type="checkbox"/>	<input type="checkbox"/>	\$					
IIM Account	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Burial Account	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Trust Funds	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Contract for Deed	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Life Estate	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Safe Deposit Box	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Whole Life Insurance (not Term Insurance)	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Uniform Transfer to Minor Account	<input type="checkbox"/>	<input type="checkbox"/>	\$					
Savings Bonds	<input type="checkbox"/>	<input type="checkbox"/>	\$				Type of Bond	Issue Date
Savings Bonds	<input type="checkbox"/>	<input type="checkbox"/>	\$				Type of Bond	Issue Date
Other	<input type="checkbox"/>	<input type="checkbox"/>	\$					

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

Property	YES	NO	Owner(S) First	(List all Co-owners) Initial	Last Name	Property Location	Value	Amount Owed
House	<input type="checkbox"/>	<input type="checkbox"/>					\$	\$
Mobile Home	<input type="checkbox"/>	<input type="checkbox"/>					\$	\$
Land	<input type="checkbox"/>	<input type="checkbox"/>					\$	\$
Building	<input type="checkbox"/>	<input type="checkbox"/>					\$	\$
Other	<input type="checkbox"/>	<input type="checkbox"/>					\$	\$

7a. If you listed a house or mobile home, is this where you live? YES  NO

**REMEMBER TO SIGN AND DATE THE FRONT PAGE.**