

**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, Bureau of Citizenship and Immigration Services (BCIS) documents 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, you are not required to provide these documents or a Social Security Number.*

**1. Tell us about yourself (Primary Individual)**

**Date Application Received by DHHS:** \_\_\_\_\_

<b>Name</b> (First, Middle Initial, Last):		<b>Social Security Number:</b> (not required for emergency services)		<b>Date of Birth:</b>	
<b>Address where you get mail</b> (include apartment number)			<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Home Address</b> (if not the same as your mailing address)			<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Your Full Name at Birth:</b> This helps us verify citizenship			<b>Your Mother's Full Name at her Birth:</b>		<b>County/State where you were born:</b>
<b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<b>Check all that apply</b> <input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<b>Are you applying for yourself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Did you receive Medical Services in the past three months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Are you currently attending school?</b> <input type="checkbox"/> Yes    What grade? _____ <input type="checkbox"/> No
<b>Do you have Health Insurance now?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, Company Name _____ Policy ID# _____					
<b>Are you the parent, stepparent, or guardian of any of the children listed on the application?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>What language do you use most?</b> <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:			<b>Race</b>	<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/Oriental <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other:	

**2. Tell us about your spouse (if you are the parent or guardian of the children and are married)**

<b>Name</b> (First, Middle Initial, Last):		<b>Social Security Number:</b> (not required for emergency services)		<b>Date of Birth:</b>	
<b>Your Full Name at Birth:</b> This helps us verify citizenship			<b>Your Mother's Full Name at her Birth:</b>		<b>County/State where you were born:</b>
<b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<b>Check all that apply</b> <input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<b>Are you applying for yourself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Did you receive Medical Services in the past three months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Are you currently attending school?</b> <input type="checkbox"/> Yes    What grade? _____ <input type="checkbox"/> No
<b>Do you have Health Insurance now?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, Company Name _____ Policy ID# _____					
<b>Are you the parent, stepparent, or guardian of any of the children listed on the application?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>What language do you use most?</b> <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:			<b>Race</b>	<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/Oriental <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other:	

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

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_

**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
<b>Full Name</b> (First, Middle, Last)			
<b>Applying for coverage for the Child?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Social Security Number</b>			
<b>Medicare or Social Security Claim Number</b>			
<b>Date of Birth of Child</b>			
<b>City, County and State where the Child was born</b>			
<b>Sex</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Mother's Full Name at her Birth</b>			
<b>Check all that apply to the Child</b>	<input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____
<b>Any unpaid Medical bills in the past three months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Race</b>	<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 _____
<b>Is the Child currently attending school</b>	<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 _____
<b>Relationship of the Child to the Primary Individual</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____
<b>Relationship of the Child to the Spouse of the Primary Individual</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____
<b>Do you pay someone for childcare for this Child while you work or attend school?</b>	Name of Provider or Daycare Center _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does Child have Health Insurance now?</b> If yes, please provide a copy of the front and back of all health insurance cards.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____
<b>Did the Child have Health Insurance in the past three (3) months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____

	Child 4	Child 5	Child 6
<b>Full Name</b> (First, Middle, Last)			
<b>Applying for coverage for the Child?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Social Security Number</b>			
<b>Medicare or Social Security Claim Number</b>			
<b>Date of Birth of Child</b>			
<b>City, County and State where the Child was born</b>			
<b>Sex</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Mother's Full Name at her Birth</b>			
<b>Check all that apply to the Child</b>	<input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____	<input type="checkbox"/> US Citizen <input type="checkbox"/> Disabled <input type="checkbox"/> Pregnant Due Date: _____
<b>Any unpaid Medical bills in the past three months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Race</b>	<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 _____
<b>Is the Child currently attending school</b>	<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 _____
<b>Relationship of the Child to the Primary Individual</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____
<b>Relationship of the Child to the Spouse of the Primary Individual</b>	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____	<input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____
<b>Do you pay someone for childcare for this Child while you work or attend school?</b>	Name of Provider or Daycare Center _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Provider or Daycare Center _____ Amount you pay: _____ How often: _____ ABC Voucher? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does Child have Health Insurance now?</b> If yes, please provide a copy of the front and back of all health insurance cards.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____
<b>Did the Child have Health Insurance in the past three (3) months?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide: Type of Policy _____ Company Name _____ Policy ID# _____ Date Policy Ended: _____ Reason Insurance ended: _____

**4. Tell us how much income your household has.**

Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks.**

Your Income from Employment	Other Parent's/Spouse's Income from Employment <i>(if living in the home)</i>
Name of person working _____ Employer's Name _____ Employer's Address _____ _____	Name of person working _____ Employer's Name _____ Employer's Address _____ _____
Is the person a South Carolina State Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer's Phone Number (including area code) _____	Is the person a South Carolina State Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? \$ _____	Gross amount earned per pay period before taxes? \$ _____
How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly
Still working? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, where did you work last? _____	Still working? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, where did you work last? _____
When did you stop working there? _____	When did you stop working there? _____
<b>Is anyone self-employed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name Self-Employment Business and/or Partnership _____	
<b>You must send copies of all the most recently filed Federal income tax forms including all schedules.</b>	

Other Income	Amount	Which family member gets this income?	How often is this income received?
Child Support	\$		
Alimony	\$		
Social Security Income	\$		
Unemployment Benefits	\$		
Veterans Benefits	\$		
Workers Compensation/Long Term or Short Term Disability	\$		
Money from Friends/Relatives	\$		
Interest	\$		
Retirement/Pensions/Annuities	\$		
Other Income ( <i>Please Explain</i> )	\$		

**5. If your family does not have any source of income, explain how your household bills are being paid.** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**6. Does anyone in your household own the following?**

Asset/Resource	Yes	No	Company name, address, and phone #; Account/Policy number; and/or Description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand					\$	
Checking Account(s)					\$	
Savings Account(s)					\$	
Certificate(s) of Deposit					\$	
Annuities/Trusts/Stocks/ Bonds					\$	
Home Property (location/description)					\$	\$
Other Property (location/description)					\$	\$
Life/Burial insurance					\$	\$
Burial Contracts					\$	\$
Burial Plots					\$	\$
Vehicles (make, model, year)					\$	\$
Retirement Account					\$	\$
Other (please be specific)					\$	\$

**7. Do you pay court ordered child support for a child outside your household?**  Yes  No

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

**8. 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.

- Most recent income tax forms including all schedules, if you are self employed.
- Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
- Bureau of Citizenship and Immigration Services (BCIS) documents 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 before, 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 Medicaid 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 Medicaid 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 Medicaid Program do 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 Medicaid 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.

**I have read the Rights and Responsibilities, or they have been read to me.**

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

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_