SC TEFRA Application

Attached is the application for TEFRA/Katie Beckett Medicaid Coverage and a cover letter from the South Carolina Department of Health and Human Services (state Medicaid agency) providing information on the TEFRA process.

Follow the TEFRA Application Checklist located on page 3 and send your completed application by mail or fax to:

South Carolina Department of Health and Human
Services Central Mail – ATTN: TEFRA
Post Office Box 100101
Columbia, SC 29202-3101

or
Fax: 1-803-255-8236

If you need assistance completing the application, our team of parents and professionals are here to provide your family with help support.
Please contact us at: 1-800-578-8750 or en Espanol: 1-888-808-7462.

Parent Applying for TEFRA:

This letter is to provide you with information about the TEFRA (Katie Beckett) program in Medicaid. We hope the following information will do three things:

1. Help you determine whether you should apply for TEFRA coverage for your child.
2. Help you understand the process that is involved in determining if a child is eligible for TEFRA coverage.
3. Provide you with information about things you can do to complete the application process as quickly as possible.

States may call their program "Katie Beckett" or TEFRA. Congress enacted this coverage option in 1982, after a child named Katie Beckett received media attention. Normally, for the first 30 days a child is in an institution, the child remains a part of the family household and the parent's income and resources are used in the eligibility decision. After 30 days, and for as long as the child continues to live in an institution, the child is considered an individual and only the income and resources of the child are counted. Katie Beckett's parents did not want their child to live in an institution and wanted to care for their severely disabled child at home. While Medicaid would cover Katie as long as she stayed in the institution, Medicaid could not assist her if she were to move back home. President Ronald Reagan read about Katie's story and had legislation introduced to add in-home care for this coverage group. This legislation gave states the option to provide similar coverage for children like Katie Beckett. South Carolina added this optional TEFRA program in 1995.

As we have established, TEFRA is a special coverage group for children who need institutional care, but whose families can, and want to, provide care in their homes. Although administered by the state, there are certain federal rules that govern eligibility and a child must meet several criteria in order to qualify. It is important to understand that a child may have a number of medical problems and still not qualify for TEFRA. A child must meet all of the following rules in order to be eligible:

- Age – must be 18 years old or younger
- Income – must be below the limit per month used for Medicaid in a nursing home. This amount changes each year. Please visit our website, scdhhs.gov, for the most current income amounts.
- Resources – must be at or below $2,000
- Living at home
- Must be possible for the child to receive adequate care in the home setting
    - The cost of the child's care to the Medicaid program cannot exceed the cost that Medicaid would incur if the child were institutionalized in a nursing home
- Disability – must meet the legal definition of disability for a child that is used by the Social Security Administration
- Need ongoing institutional care
    - This is called the Level of Care determination. This generally means nursing home care or Intermediate Care for Intellectual Disability/Related Disabilities. It can also mean long-term care in a hospital. This criterion is NOT met because a child may need to be admitted to a hospital many times a year to address health crises or corrective procedures

South Carolina is fortunate to have an organization called Family Connection of South Carolina, Inc., that is devoted to helping parents with children with chronic illnesses, disabilities, and developmental delays. This organization provides a support network for families like yours. You may contact Family Connection at 1-800-578-8750. They may also be able to help you with this application process. Most TEFRA applications take up to 90 days to process; however, many take longer. Family Connections can help you to collect and submit all required information with your application so that it may be processed more quickly and smoothly.

The South Carolina Vocational Rehabilitation Department (VR) performs the required disability determinations for SCDHHS. VR will request medical records from the physicians and healthcare providers that you identify on your application and will evaluate the information to make a disability decision. Please encourage your healthcare providers to provide the requested information quickly. Physicians and other healthcare providers frequently respond more quickly to you, the parent, than to a government agency like SCDHHS. Anything you can do to get the medical records more quickly will help us process the application. If you do obtain medical records, send them along with your application. If you receive medical records after you send in your application, you can FAX, email, or mail them to us. Please FAX these records to 888-820-1204, email them to 8032558296@fax.scdhhs.gov, or mail them to:

South Carolina Department of Health and Human Services
Central Mail – Attn: TEFRA
Post Office Box 100101
Columbia, SC 29202-3101

If the medical records do not clearly indicate disability, a VR specialist will be assigned to review your child's condition to determine if there is more information that might lead to a positive determination of disability. This step lengthens the process, but is necessary to give your child every chance of meeting disability criteria.

At the same time the disability determination is in process, we review your child's condition to determine whether he or she needs institutional care. This is called Level of Care, or LOC. To meet the medical necessity criteria for institutional care, a person has to have functional deficits in daily living skills. For an adult, this means that he or she cannot bathe, dress, eat or transfer (move) without ongoing assistance. For a child, the determination is more difficult since the deficits are not simply the age-appropriate dependences of a child.

All children are dependent at birth for assistance in these areas. Therefore, the normal dependency of an infant is age appropriate. It does not mean that they need institutional care. We first look at your child's functional level compared to the functional level expected for a child of your child's age. The first review is to see whether your child's functional level is so different from the expected level that he or she would require ongoing care in a nursing home. If your child does not need to live in a nursing home, we then send the application to the South Carolina Department of Disabilities and Special Needs (DDSN) for a second review. DDSN reviews your child's condition to determine if your child has an Intellectual or Related Disability and if your child needs ongoing care in an Intermediate Care Facility for the Intellectual Disability/Related Disabilities (ICF-ID/RD). If your child does not need to live in a nursing home, and does not need ongoing care in an Intermediate Care Facility, a final review will be conducted to see if your child requires hospital level of care treatment.

As you can see, this is a lengthy process. It is lengthy because we make every effort to find your child eligible. These efforts may include finding additional specialists to review your child's condition if medical records do not support a disability determination and home visits related to Level of Care determinations.

We hope this letter provides you with a better understanding of TEFRA and the requirements to qualify. If you would like to provide us with any additional information that could be helpful, or you would like to send us a written statement about your child's condition, please do so with your application. We will include your statement and/or the additional information in the material used in both the disability determination and the Level of Care determination. Also, please encourage your child's physicians and healthcare providers to respond quickly to requests from us for medical records.

Please understand that your child may have severe medical problems and still not meet TEFRA requirements. The lack of need for continuous institutional care frequently disqualifies a child. A denial does not mean that we do not think your child has serious medical problems or is seriously ill.

TEFRA Application - Checklist

By providing as much information as possible when you apply, SCDHHS may be able to process your application in a shorter time. Be sure to include these items when you apply. If you are not sure what to send, call our toll-free line at 1-888-549-0820 TTY 1-888-842-3620 for help.

- ☐ Application Form – DHHS Form 3290
- ☐ DHHS Form 3291ME, TEFRA In-Home Care Certification. Your child's physician must complete this form.
- ☐ DHHS 3218D-ME –Disability Report, Child Under Age 19. It is important that you fill out each blank, even to indicate not applicable (N/A).
- ☐ DHHS Form 921 – Request for Medical Records. To save time, you may also provide one extra signed copy of Form 921 in case we need to make further requests on your behalf.
- ☐ SC Department of Disabilities and Special Needs Permission to Evaluate TEFRA Applicant Form. Sign and return this form.
- ☐ Proof of ☐ Citizenship ☐ Identity (Photocopies of original documents required.)
- ☐ Photocopies of any recent medical records (within one year) you may have regarding your child's health. These are not mandatory but may help speed up the application process.
- ☐ Copies of recent IEP and School Psychological Evaluation for school-age children
- ☐ Proof of any income that your child receives, such as child support or Social Security
- ☐ Proof of any resources available to your child such as bank accounts, savings bonds, trust accounts, life insurance policies, etc.
- ☐ Copies of any health insurance card, front and back, showing that your child is covered. This does not affect your child's eligibility for Medicaid. We need a record of other insurance, if applicable.

Send the completed, signed application and other required forms and information by:

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

OR

Fax: 1-888-820-1204

Why do we ask for this information?
We ask about income and asset 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, please visit: **www.scdhhs.gov**

What happens next?
Send your complete application to the address at the end of the form. If you don't have all the information we ask for, submit your application anyway; we'll follow up with you. If you don't hear from us, visit SCDHHS.gov or call 1-888-549-0820.

Get help with this form

- Visit us online at SCDHHS.gov
- Call our Member Contact Center at 1-888-549-0820.
- In person: Visit an SCDHHS county eligibility office in your area.

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We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check eligibility for health coverage.

Your Information (Person Applying for Child)

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

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

3. Gender: ☐ Male ☐ Female

4. Relationship to Applicant (Child)

5. Home address

6. Apartment or suite #

7. City

8. State

9. ZIP code

10. County

11. Mailing address (if different from home address)

12. Apartment or suite #

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 child's parent/guardian/caregiver.

21. Application start date (mm/dd/yyyy)

22. First name, Middle name, Last name, & Suffix

23. Organization Name (if applicable)

24. ID Number (if applicable)

Tell us about yourself (child's parents/guardians/caregiver)

Parent / Guardian 1

25. First name, Middle initial, Last name, & Suffix		26. Relationship to Child?
27. Date of birth	28. Gender	29. Social Security Number

30. Does Parent / Guardian 1 live at the same address as the child? ☐ Yes ☐ No

Parent / Guardian 2

31. First name, Middle initial, Last name, & Suffix		32. Relationship to Child?
33. Date of birth	34. Gender	35. Social Security Number

36. Does Parent / Guardian 2 live at the same address as the child? ☐ Yes ☐ No

37. Does anyone have Conservatorship, Guardianship or Power of Attorney for the applying child. If yes, please give us a copy of the legal or court papers and the name and phone number of the person.

☐ Conservatorship Name and phone: _____

☐ Guardianship Name and phone: _____

☐ Power of Attorney Name and phone: _____

Please tell us about the applicant (child).

38. First name, Middle initial, Last name, & Suffix

39. Child's Full Name at Birth (if different from above)	40. Mother's Full Name at Her Birth

41. Date of birth	42. Gender	43. Social Security Number*	44. If no SSN, has child applied for one? ☐ Yes ☐ No If no, see question 45

*** We need this if the child wants health coverage and has an SSN.** Providing an SSN can be helpful since it can speed up the application process. 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.

45. If you have not applied for a Social Security Number for the child, please list the reason:

☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN

☐ Newborn, mother NOT receiving Medicaid ☐ Newborn, mother currently receiving Medicaid

46. **Child's Race (OPTIONAL—check all that apply)**

☐ White ☐ Native Hawaiian ☐ Vietnamese ☐ Korean ☐ Black/African American

☐ Chinese ☐ Japanese ☐ Guamanian or Chamorro ☐ Asian Indian

☐ Samoan ☐ Filipino ☐ American Indian or Alaska native

☐ Other Pacific Islander ☐ Other: _____

47. **If Hispanic/Latino, ethnicity (OPTIONAL)**

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

48. Is the child 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

49. Is the child a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

50. If the child isn't a U.S. citizen or U.S. national, does he/she have eligible immigration status? ☐ Yes ☐ No
If YES, fill in the document type and ID number below.
a. Immigration document type: _____ b. Document ID number: _____
c. Has the parent lived in the U.S. since 1996? ☐ Yes ☐ No
d. Date of Entry: _____
e. Is the parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

51. Do you want help paying the child's medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was the household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was the child's income the same during these 3 months as it is now? ☐ Yes ☐ No
If NO, enter the total monthly income for:
Last Month: $ _____ 2 Months Ago: $ _____ 3 Months Ago: $ _____

52. Is the child a full-time student? ☐ Yes ☐ No

53. Does the child have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
a. If YES, When did the disability begin? _____

54. Is the child blind? ☐ Yes ☐ No

55. Is the child currently in a Hospital, Nursing Home, or Residential Care Facility? ☐ Yes ☐ No
a. If YES, Please enter the name of the Hospital, Nursing Home, or Residential Care Facility: _____
b. Date Entered? _____

56. Does the child need to live in a medical facility or nursing home? ☐ Yes ☐ No

57. Does the child need nursing services at home? ☐ Yes ☐ No

58. Does the child need to go into a Residential Care Facility? ☐ Yes ☐ No

59. Is the child pregnant or recently pregnant? If YES, ☐ Yes ☐ No
a. How many babies are expected? _____ b. What is the due date? _____
c. If recently pregnant, enter the date the pregnancy ended: _____
d. Was the child enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

60. Has the child been diagnosed with and receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia
• Precancerous Cervical Lesion (CIN 2/3)

Please tell us about the applicant's employment status

61. Does the child work? ☐ No ☐ Yes If yes, check employment type:

☐ **Employed**
If currently employed, tell us about the income below.

☐ **Not Employed**
SKIP to question 69.

☐ **Self-Employed**
SKIP to question 68.

CURRENT JOB

62. Employer name and address _____

63. Employer phone number _____

64. Wages/tips (pre-tax) $ _____

☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

65. Average hours worked each week _____ 66. Start date _____

67. In the past year, did child: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours

68. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income will child get from this self-employment this month? $ _____

OTHER INCOME THIS MONTH

69. Check all income sources that apply and complete the table below.

☐ Child Support ☐ Veteran Benefits ☐ Unemployment ☐ Net farming/fishing
☐ Pensions ☐ Net rental/royalty ☐ Social Security ☐ Workers Comp
☐ Retirement acc'ts ☐ Disability ☐ Alimony received ☐ Cash Contributions
☐ Other income

Income Source	How often received	Amount received	Comments
		$	
		$	
		$	
		$	
		$	
		$	

70. **DEDUCTIONS:** Check all that apply, and give the amount and how often the child gets it.
If the child 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. **NOTE:** You shouldn't include a cost that was already considered in the answer to net self-employment.

☐ Alimony paid $ _____ How often?_____ ☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $_____ How often? ___Type: _____

71. **YEARLY INCOME: Complete only if the income changes from month to month.**

Child's total income this year
$ _____

Child's total income next year (if you think it will be different)
$ _____

Please tell us about the child's resources

72. Does the child own any property? (Include property in other states.) ☐ Yes ☐ No
If YES, check the boxes that apply and tell us about the property.

☐ Home (house, buildings and land where you live)
☐ Other House or Building (not your home)
☐ Land (not connected to current home)
☐ Vacation Home or Time Share Property

a. What is the address of the property? (List home property first)

_____

_____

_____

Owner's Name: _____

b. What is the address of the property?

_____

_____

_____

Owner's Name: _____

Is "a." above the child's home property or primary residence where he/she currently lives or where he/she wants to return to live, if living somewhere else? ☐ Yes ☐ No

73. Please check the box beside any of the items that the child owns or is buying. Tell us about it in the table below.

☐ Bank Checking Account
☐ Bank Savings Account
☐ Car, Truck, Van
☐ Certificate of Deposit
☐ Motorcycle, Boat, Camper
☐ Annuity (provide a copy)
☐ Trust Fund or Trust Account
☐ Pre-Need Burial Contract
☐ Cash on Hand
☐ Money Set Aside for Burial
☐ Cemetery Burial Space
☐ Life Insurance
☐ 401k, IRA, or Retirement Account
☐ Stocks, Bonds, Mutual Funds
☐ Farm Machinery or Business Equipment
☐ DirectExpress Debit Card for SSA, SSI or other benefits
☐ Other: _____

Owned by	Tell Us About the Asset Include the name of bank or funeral home and any account numbers or other information used to identify the asset.	Current Value or Balance
		$
		$
		$
		$

74. Does the child have private health insurance, Medicaid from another state, or Medicare? ☐ Yes ☐ No
If yes, complete the table below:

Policy Holder	List everyone covered by the insurance	Name of Insurance Company	Policy, Medicaid or Medicare ID Number

Please include a copy of the front and back of all health insurance cards

STEP 3 American Indian or Alaska Native (AI/AN)

Is the child an American Indian or Alaska Native?

☐ **If NO,** skip to Step 4.

☐ **YES. If YES,** ask for and complete SCDHHS Form 3400-Appendix B

STEP 4 Rights and Responsibilities

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 Medicaid 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, SCDHHS 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.
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).

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

Renewal of coverage in future years
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign 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.

Send in the completed application.

Mail your signed application to: **SCDHHS - Central Mail**
PO Box 100101
Columbia SC 29202-3101

OR Fax: 1-888-820-1204

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, contact Janet Bell, ADA and 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 that 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 or by mail or 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

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

TEFRA
In-Home Care Certification

This box for SCDHHS Use Only Case HH#: _____

This form is to be completed by the applicant's physician. Certification that the applicant may be cared for in a home setting, even though his/her medical condition may warrant acute or institutional care, is a requirement for Medicaid eligibility under the TEFRA program and in no way holds the physician responsible for the applicant's in-home care.

APPLICANT INFORMATION

Applicant Name (First, Middle, Last) (Print)		Phone	
Street Address	City	State	ZIP
Medicaid ID (if applicable)	Date of Birth	Social Security Number	

PHYSICIAN INFORMATION

Physician Name (First, Middle, Last) (Print)			
Street Address	City	State	ZIP
Phone	Fax		

PHYSICIAN'S STATEMENT

As of the date listed below, I agree that it is appropriate to provide care at home for:

_____ (Child's full name).

_____ _____

Physician's Signature Date

ROUTING INSTRUCTIONS

MAIL TO: SCDHHS - Central Mail
PO Box 100101
Columbia, SC 29202

OR

FAX TO: (803) 255-8236

NOTE

Questions regarding the completion of this statement or the TEFRA program should be directed to the South Carolina Department of Health and Human Services at (888) 549-0820.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Medicaid Disability Report

Date:_____

The South Carolina Vocational Rehabilitation Department (SCVRD) – Disability Determination Services State Claims Office assists with processing SC Department of Health and Human Services (DHHS) Medicaid disability claims. SCVRD also contacts medical treatment sources where you have been seen and requests copies of your medical records.

- **Please complete the enclosed two forms:**
  - **Disability Report**
  - **Authorization to Disclose Health Information (Form 921)**
- **Please answer every question and return all the pages of these forms.**
- **Mark as "N/A" if a question does not apply to you.**

If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed application.

Mail To:

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

An addressed envelope is included for your convenience.

IMPORTANT: If you have not applied for Social Security Disability Benefits or Supplemental Security Income Benefits (SSI) within the last 12 months, be sure to apply online (socialsecurity.gov), at the Social Security office, or by phone as soon as possible.

If you have questions about completing this form, please call the
Healthy Connections Member Services Center toll free at:
(888) 549-0820 (TTY 888-842-3620)

If you do not return the completed Medicaid Application, Disability Report, and the Authorization to Disclose Health Information form, we cannot determine your disability or Medicaid eligibility.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Child Disability Report - Checklist

Along with your Medicaid Application, completion of all enclosed forms is required. Forms with incomplete information will result in delays or could result in a denial of the claim.

If you need assistance completing the forms in this packet, please call the Healthy Connections Member Services Center at **888-549-0820 (TTY 888-842-3620)**. Use the following checklist as a guide to ensure the forms are properly completed.

Disability Report or Continuing Disability Report (Form 3218-D or 3266-D)

- ☐ Complete in BLUE OR BLACK INK.
- ☐ Provide correct social security number, date of birth, address, and phone number for child.
- ☐ Provide contact information for additional adult familiar with child's condition.
- ☐ Complete information on child's school and/or day care.
- ☐ List all of the doctors, hospitals, and treating facilities where child has been treated for a medical condition(s) in the last 15 months.
- ☐ Provide a copy of the death certificate or death summary from the hospital if applying on behalf of an individual who has died.
- ☐ Answer every question and return all the pages of these forms.
- ☐ Mark as "N/A" if a question does not apply to you.

Authorization to Disclose Health Information (Form 921)

- ☐ Complete in BLUE OR BLACK INK.
- ☐ Sign and date by parent or legal guardian
- ☐ If applicant is age 12 to 18, he/she must sign in addition to the parent or legal guardian
- ☐ **If there is a legally appointed representative or power of attorney document, *please include a copy with completed and signed form.***

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Disability Report - Child Under Age 19

Send to: SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

☐ Presumptive Disability
This box for pilot use only

*If you need assistance, please call the Healthy Connections Member Services Center toll free at **(888) 549-0820 (TTY 888-842-3620)**.*

FOR DHHS USE ONLY

☐ Child Initial ☐ Retro Only Date of Last Update: ___ / ___ / ___

Number of pages received and scanned: _____

Household Number: _____ Application Date: ___ / ___ / ___ Retro: _____

Please fully complete this form and return with the signed Authorization to Disclose Health Information form in the provided envelope. It is very important that you provide complete addresses and phone numbers for your medical sources. If the form is not completed fully, it will delay the processing of your Medicaid Disability claim.

It is critical that the enclosed Authorization to Disclose Health Information form is signed **IN BLACK OR BLUE INK** by the PARENT OR LEGAL GUARDIAN of the minor child. **If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed form.**

CHILD'S INFORMATION

Child's Last Name: _____ Child's First Name: _____ Middle Initial: ___

Child's SSN#: - - Child's Previous Name (if applicable): _____

Date of Birth:_____/_____/_____ Date of Death (If Applicable):_____/_____/_____

Street Address: _____ City: _____ State: ____ ZIP: _____

PARENT/GUARDIAN INFORMATION

Parent / Guardian: _____

Relationship to Applicant: _____ Phone: - -

Parent / Guardian's Address: ___ _____ City: _____ State: ____ ZIP: _____

What is your preferred spoken or written language (if not English)?

What is your child's disability?

Explain how the child's disability affects his/her ability to function. (You may add additional pages, if needed.)

Please provide the name of someone who knows about your child's condition (not a doctor or teacher). Examples: neighbor, grandparent, etc.

Name of Contact: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Relation to Child: _____

SCHOOL/TRAINING INFORMATION

Is the child currently attending school (or preschool)? ☐ Yes ☐ No If yes, please complete the following: Current Grade: _____ Primary Teacher's Name: _____

Name of School: _____

Address: _____

Is the child in a special education program? ☐ Yes ☐ No School Phone Number: _____

If yes, please list teacher's name: _____

At school, does the child receive:

☐ Yes	☐ No	Occupational Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Speech Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Physical Therapy?	Therapist Name:	_____
☐ Yes	☐ No	ABA Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Other Services?	Service Provider Name:	_____

If you have a copy of student's IEP, please include a copy with completed application.

Does the child attend a day care or after school program? ☐ Yes ☐ No

Name of Program: _____ Type of Program: _____

Phone Number: _____ - _____ - _____ Teacher/Program Provider: _____

Street Address: _____ City: _____ State: ____ ZIP: _____

Please provide a complete address for all medical and service providers so we may request medical educational and treatment records. If you need additional space, use the "remarks" section or attach additional pages.

MEDICAL TREATMENT: List ALL doctors seen in a clinic or doctor's office in the last 15 months.

1. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

2. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

3. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

List ALL **hospitals, emergency rooms, or urgent care facilities** the child has visited in the last **15 months**. List the name of facility only; we do not need individual names of doctors.

1. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

2. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

3. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

4. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

List ALL **THERAPY PROVIDERS (outside of school setting)** that the child has visited in the last **15 months**. In this section please list all **Occupational Therapy, Physical Therapy, Speech Therapy**, etc. *Please provide complete contact information for each provider*. ***If services are coordinated through BabyNet, it is still necessary that you provide us with the contact information for each individual provider, as we are not always able to obtain records from BabyNet directly.***

1. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

2. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

3. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

4. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

5. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

List any additional places where you have had tests or imaging (blood work, xrays, CTs, etc) performed in the last 15 months **if facility has not already been listed above**.

1. Facility Name: _____ Date Last Seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

2. Facility Name: _____ Date Last Seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

REMARKS

Use this space to provide additional information that may help make a decision on your disability claim.

Please remember to sign and return the Authorization to Disclose Health Information form, Form 921.

Clear Form

South Carolina Department of Health and Human Services (SCDHHS)
Eligibility, Enrollment and Member Services
Toll-free (888) 549-0820 TTY (888) 842-3620

Authorization to Disclose Health Information

For Office Use Only – **TO BE COMPLETED BY SCDHHS**			
Applicant/Beneficiary Name *(First)* *(Middle)* *(Last)*			
Social Security No.	**Date of Birth**	**Household No./App ID** _ _ _ _ _ _ _ _ _	

**** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW.****

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) of:

WHAT: ***All my medical records, education records and other information related to my ability to perform tasks. This includes specific permission to release the following:***

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually-transmitted diseases
   - Gene-related impairments, including genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work
3. Copies of education tests or evaluation, including individualized educational programs, triennial assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate function
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM:
- **All** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.), including mental health, correctional, and addiction treatment and VA health care facilities
- All educational sources (schools, teacher records, administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials**)**

THIS BOX TO BE COMPLETED BY SCDVR (as needed) for additional information to identify the subject (e.g., other names used), the specific source, or the material to be used.

_____

_____

_____

_____

TO WHOM: The State agency authorized to process my case (usually called "SCVRD") including contract copy services, doctors, or other professionals consulted during the disability determination process.

PURPOSE: I agree to the disclosure of my health information to determine if I meet the disability criteria in order to establish my eligibility for Medicaid benefits

EXPIRES WHEN: This authorization is binding for 12 months from the date signed below.

I UNDERSTAND THAT:
- I may write to The South Carolina Department of Health and Human Services to revoke this authorization at any time.
- There are some circumstances where the information may be re-disclosed to other parties involved with the Medicaid eligibility determination.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

Applicant Signature (Person Applying for Benefits OR Parent/Guardian if Applicant is Under Age 18):	**Relationship to Applicant:**
Legal Representative Signature (if Applicant is Unable to Sign Due to Health):	**Date:**
Child Signature (Required if Applicant is Age 12 to 18):	☐ **Power of Attorney or legal guardian documentation is attached if signed by a Legal Representative.**
Witness:	**Witness if signed with an "X":**

AUTHORIZATION FOR RELEASE OF INFORMATION TO SC VOCATIONAL REHABILITATION DEPARTMENT (SCVRD)

We need your written authorization to help get the information required to process your application for benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing Form 921. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. Some sources of information require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to the South Carolina Dept. of Health and Human Services, Enrollment and Member Services, P.O. Box 8206, Columbia, S.C. 29202-8206. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. SCDHHS can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SCDHHS to decide your claim.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SCDHHS/SCVRD is protected by the Privacy Act of 1974. Once medical information is disclosed to SCDHHS/SCVRD, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA). SCDHHS/SCVRD retains personal information is strict adherence to the State regulations 19-903, 19-933, 19-963, and 19-983.

We use the information obtained with this form to determine your eligibility for benefits. In some cases, your information may also be reviewed by SCDHHS personnel and contractors that process your appeal of a decision and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim and could result in denial or loss of benefits.

South Carolina Department of Disabilities and Special Needs Eligibility Division

Permission to Evaluate TEFRA Medicaid Applicant

I, _____ (print name of applicant), have applied for Medicaid eligibility as part of the national Tax Equity and Fiscal Responsibility Act (TEFRA) through the South Carolina Department of Health and Human Services (SCDHHS). As part of this Medicaid eligibility determination process, I understand that the South Carolina Department of Disabilities and Special Needs (SCDDSN) will determine whether I meet the level of care criteria for an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). I further understand that this is not a request to determine my eligibility for care, treatment, training, or residential services from SCDDSN. However, I also understand that I may make a separate request for eligibility for SCDDSN services.

I give permission for SCDDSN to review any available medical, educational, and/or other records pertaining to me in order to determine whether I meet ICF/IID level of care criteria. I understand that I may be asked to sign one or more separate authorization forms for release of this information to SCDDSN.

I understand that this document will remain in effect until such time as SCDHHS makes a Medicaid eligibility decision under TEFRA including actions under appeal. I understand that I may terminate this permission in writing to SCDDSN or its designated representative at any time.

_____ _____

Applicant's Signature Date

or

_____ _____

Legal Guardian's Signature Date
(For applicant under 18 yrs. or legally incompetent)

10/29/2020