

Nursing Home

In-Home Care

This form is used to gather other information needed to make a decision about eligibility for Nursing Home, Institutional or In-Home Care. Please answer the following questions as completely as possible as they apply to **the person who is applying and their spouse**. If you are applying on behalf of someone else, enter your name as the Authorized Representative. The rights and responsibilities you agreed to on the original application are still in effect. If you have questions, please contact Healthy Connections at (888) 549-0820 (TTY 1-888-842-3620). We may ask for additional information or documentation to establish your eligibility.

Name of person needing assistance (First, Middle, Last)

Social Security Number	Medicaid ID	Date of Birth (mm/dd/yyyy)
Authorized Representative (if applicable):		Relationship to Applicant

I. Statement of Transfers

1. In the past five years have you: Yes No
- Closed a Bank Account Closed an Investment Account Closed a Retirement Account
- Transferred Life-Estate Interest In Your Home or Any Other Property

If YES, fill in the following values, if known:

Accounts

Account	Date Closed	Closing Balance	Account	Date Closed	Closing Balance
		\$ _____			\$ _____
Account	Date Closed	Closing Balance	Account	Date Closed	Closing Balance
		\$ _____			\$ _____

Life Estate Interest

Property	Transfer Date	Appraised Value	Property	Transfer Date	Appraised Value
		\$ _____			\$ _____

2. In the past five years have you sold or given away your home? Yes No

If YES, fill in the following, if known:

Appraised Value Sale Price
 \$ _____ \$ _____

3. In the past five years have you sold or given away other real estate? Yes No

If YES, fill in the following values, if known:

Property	Appraised Value	Sale Price	Property	Appraised Value	Sale Price
	\$ _____	\$ _____		\$ _____	\$ _____
Property	Appraised Value	Sale Price			
	\$ _____	\$ _____	TOTAL	\$ _____	\$ _____

4. In the past five years have you sold or given away any motor vehicles, boats, or other recreational vehicle? Yes No

If YES, fill in the following values, if known:

Vehicle	Appraised Value	Sale Price	Vehicle	Appraised Value	Sale Price
_____	\$ _____	\$ _____	_____	\$ _____	\$ _____
Vehicle	Appraised Value	Sale Price			
_____	\$ _____	\$ _____	TOTAL	\$ _____	\$ _____

5. In the past five years have you given away cash? Yes No

If YES:

Person to whom it was given	Date given	Amount
_____	_____	\$ _____
_____	_____	\$ _____

CLTC Worker (If Applicable) (Print)

CLTC Worker Signature

Date

II. Additional Information

6. Please check if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant. If yes, please enclose a copy of the legal papers.

- Conservatorship Name: _____ Phone _____
 Guardianship Name: _____ Phone _____
 Power of Attorney Name: _____ Phone _____

7. Where is the applicant right now? Home Hospital Nursing Home Other

If not at home, tell us where the applicant is:

Name of facility: _____

Date entered facility: _____

Did the applicant live at home at any time during the month he/she entered the nursing facility? Yes No

8. Where has the applicant lived in the past five (5) years?

Street Address	City	County	State	From (date)	To (date)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

9. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to a spouse remaining at home? Yes No

10. Does the applicant want to give (allocate) income to dependent adults living in the home or to dependent children? Yes No

11. Does anyone in the applicant's home (including the applicant or applicant's spouse, children or dependent adults) receive or has anyone applied for any other income? Yes No

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks. In addition to the income you listed on your application, do you have any of the following? If YES, check all boxes that apply and complete the table below.

- Supplemental Security Income (SSI) Child support Disability benefits
 - Veterans Administration (VA) benefits Military Allotments Other
 - Federal Retirement (Civil Service, FERS) Money from friends or relatives
 - Land contract, mortgage or other notes payable to a household member.
- (Please provide a copy of the contract, mortgage, note or other agreement.)

Person receiving/expecting money	Income source/type	How often received	Amount received
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

12. Has the applicant or spouse ever worked somewhere that has a retirement benefit, military retirement or VA benefit for which he or she may be eligible to receive money? Yes No

If YES, who was working? _____

Where? _____

For how long? _____

13. Has the applicant received an inheritance in the last five years? Yes No

If YES, from whom? _____

Date of Death: _____ State/County where estate was probated _____

Additional Inheritance

If YES, from whom? _____

Date of Death: _____ State/County where estate was probated _____

14. Do you or your spouse own any property? (Include property in other states.) If YES, check the boxes that apply and tell us about the property. Yes No

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

a. What is the address/location of the property? **b. What is the address/location of other property?**
 (List home property first)

Owner's Name: _____ Owner's Name: _____

Is 14-a your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else? Yes No

15. Please check the box beside any of the items that the applicant, applicant's spouse or applicant's dependent(s) owns or are buying. Tell us about it in the table below.

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

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

Owned by	Tell Us About the Asset	Current Value or Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

NOTE: When you return this form, you must send proof of these assets or resources, including any supporting documents. You will be asked to send information for the month of application and at least three months prior to the application month.

16. If ever married, give the following information about the applicant's spouse(s).

Never been married

Name of most recent spouse: _____

Living

In a medical facility

Separated: When or How Long? _____

Married, living together

Divorced

Married, living apart

Current Street Address

City

State

ZIP

Phone

Deceased - Date of Death: _____ State/County where estate was probated _____

Name of most recent spouse: _____

Living

In a medical facility

Separated: When or How Long? _____

Married, living together

Divorced

Married, living apart

Current Street Address

City

State

ZIP

Phone

Deceased - Date of Death: _____ State/County where estate was probated _____

ESTATE RECOVERY

(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE)

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, the Department of Health and Human Services may 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.

Applicant or Authorized Representative's Signature | **Date**

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

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: 1-888-808-4238 (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).

خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-549-0820 (رقم هاتف الصم والبكم: 1-888-842-3620).
إذا كنت تتحدث اذك اللغة، فإن

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 लिए 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).

နမူနာကတိကညီ ကျိုင်အယိ, နမူနာ ကျိုင်အတိမာစာလီ တလင်ဘျာလင်စွါ နိတမံဘျာသ့န့လီ. ကိ: 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚገኙት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620)።

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ၎င်းအတွက်

စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ်ဆိုပါ။