SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

APPLICATION FOR THE MEDICALLY INDIGENT ASSISTANCE PROGRAM

I. APPLICANT – IDENTIFYING INFORMATION

☐ Emergency ☐ Non-emergency Admission Date _____

Hospital _____

Applicant Name _____ Social Security No. _____

Date of Birth _____ Race _____ Sex ____ Marital Status _____

Telephone: Home _____ Work _____ County of Residence _____

Mailing Address _____

Address where you live (if different) _____

How long at this address? _____ If less than 6 months, give previous address, including county

_____

Is applicant a minor who does not live in the home of his parent(s)? ☐ Yes ☐ No

If yes, give parent(s) name, address, and county of residence _____

_____

Is the applicant a citizen or permanent resident alien? ☐ Yes ☐ No

_____

II. THIRD PARTY INFORMATION ON APPLICANT

1. Do you have any other health insurance? ☐ Yes ☐ No
   If yes, give name of company and number for each policy _____
   _____
2. Is illness due to an accident? ☐ Yes ☐ No If yes, what type? _____
   Date of accident _____ Is claim pending? ☐ Yes ☐ No
   If work-related, give name and address of employer at time of accident _____
   _____
3. Are you covered by Medicare? ☐ Yes ☐ No If yes, give Medicare claim number _____
4. Are you pregnant or were you pregnant at admission? ☐ Yes ☐ No
5. Do you receive or have you applied for Medicaid? ☐ Yes ☐ No Date Applied _____
   If receiving, give Medicaid number _____
   Name of Medicaid worker (if known) _____
6. Have you applied for hospital services through another government program? ☐ Yes ☐ No
   If yes, check all blocks that apply. ☐ Veterans Administration ☐ DHEC
   ☐ Commission for the Blind ☐ Other (specify) _____ Date Applied _____

III. MEMBERS OF THE APPLICANT'S FAMILY

Name	Relationship to Applicant	Date of Birth and/or Age	Marital Status

IV. INCOME

1. Do you or other family members have income? ☐ Yes ☐ No (Income includes wages or salary before deductions, net receipts from self-employment, regular public assistance payments such as Family Independence or SSI, Social Security, Veterans benefits, pension or other retirement income, unemployment compensation, workmen's compensation, child support or alimony, interest income, etc.)

Name of Family Member	Gross Income	Frequency	Name and Address of Source

2. If not working now, when was your last day of employment? _____
   Name and address of employer: _____
3. Have you or anyone in your family received a lump sum payment in the past four (4) weeks (income tax refund, insurance settlement, etc.)? ☐ Yes ☐ No
   If yes, amount received _____ From whom? _____

V. RESOURCES

1. Do you or other family members own real property (home, land, buildings, life estates, mobile homes, etc.)? ☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Amount Owed, if any

2. Do you or other family members own taxable personal property (cars, trucks, boats, vans, mobile homes (other than home), motorcycles, or other kind of vehicle)? ☐ Yes ☐ No If yes, give the following information:

Type	Registered Owner(s)	Year, Make, and Model	Amount Owed, if any

3. Do you or other family members own liquid assets (cash on hand, checking accounts, savings accounts, U.S. Savings Bonds, stocks, trust funds, certificates of deposit, face value of life insurance, individual retirement accounts, etc.)? ☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Account Number	Amount/Value

VI. TRANSFER OF RESOURCES

Have you or other family members sold or given as a gift any resources in the past three (3) months?
☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Account Number	Amount/Value

VII. STATEMENT OF UNDERSTANDING

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under the Medically Indigent Assistance Act.

I understand that if I believe an error has been made by the MIAP county designee in processing my MIAP Application, I may request a reconsideration. This request must be made in writing, within 30 days from the date of the decision notice, to the person designated by the county's chief administrative officer to make reconsideration decisions. I understand that if I believe an error has been made in the reconsideration decision, I may request a fair hearing by the Department of Health and Human Services (DHHS) by sending my written request with a copy of the reconsideration notice to: Division of Appeals, DHHS, Post Office Box 8206, Columbia, South Carolina 29202-8206.

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud. By my signature, I authorize the release of any information needed to determine my eligibility for the Medically Indigent Assistance Program, and I authorize the MIAP county designee to provide a copy of this application to a Medicaid eligibility worker.

Applicant's Signature:		Date:
Signature of Responsible Person or Authorized Representative:	Title/Relationship:	
Address:		Date:
Witness (signature by a mark "X" requires two witnesses):	Witness:	Date:
County Designee Signature:		Date:

VIII. CASE NOTES

WORKSHEET

The eligibility factors identified below must be met before an applicant can be certified for assistance through the MIAP. Please indicate if each factor is met and how it was verified.

1. Is applicant a state resident? ☐ Not questionable ☐ Questionable
   If questionable, how verified? _____

2. Is applicant a citizen or a permanent resident alien? ☐ Not questionable ☐ Questionable
   If questionable, how verified? _____

3. Number of Family Members …… ☐
   Explain who was included/excluded in the family composition and why.

   Family Income – Whose income was included in the calculation?

   How was it verified and calculated?

TOTAL GROSS ANNUAL INCOME ☐

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4. Family Resources
   A. Home Property (Identify the asset, to whom it belongs, and the equity value.)

   Method and date of verification

   MIAP Limit $35,000.00

TOTAL VALUE OF HOME PROPERTY ☐

   B. Non-home real property and taxable personal property (Identify the asset, to whom it belongs, and the equity value.)

   Method and date of verification

   MIAP Limit $6,000.00

TOTAL VALUE OF NON-HOME REAL AND TAXABLE PERSONAL PROPERTY ☐

   C. Liquid Assets (Identify the asset, to whom it belongs, and the value.)

   Method and date of verification

   MIAP Limit $500.00

TOTAL VALUE OF LIQUID ASSETS ☐

   Does the value of the applicant's liquid assets (4C) exceed the MIAP limit? ☐ Yes ☐ No
   If yes, by how much? $_____

   Did the applicant spend the excess on valid debts of the family that were incurred within thirty (30) days of the hospitalization? ☐ Yes ☐ No If yes, how verified? _____
   _____