Desk REFERENCE

Track: Non-MAGI

3400, 3400-01, 3400-A, 3400-B, 3401 Application Forms to Cúram Crosswalk

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

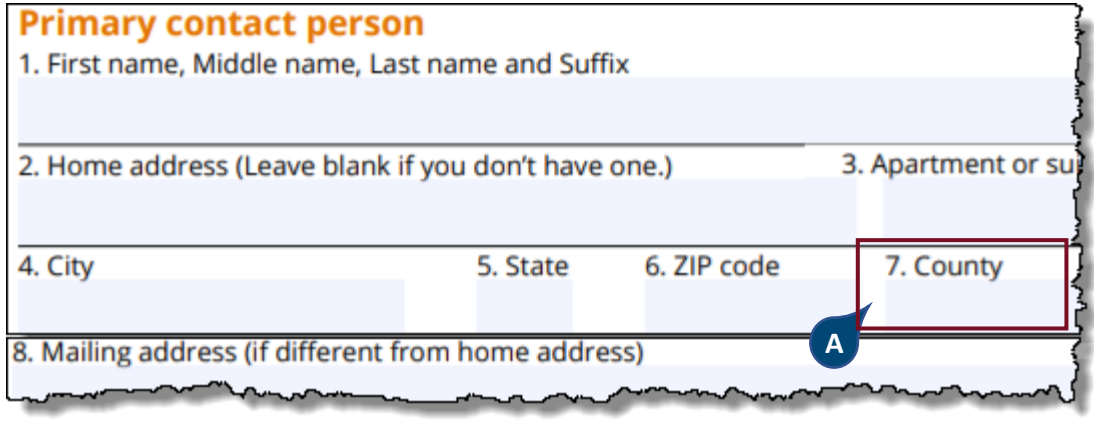
PURPOSE

The purpose of this Desk Reference is to provide a crosswalk between questions presented on paper forms 3400 and 3400-A and where the questions are in the the Non-MAGI Application Wizard in Cúram. This helps those users who are new to Cúram to locate information. This guide is simply a crosswalk between questions presented. For detailed steps on how to enter a Non-MAGI Application, please see the **Enter a New Non-MAGI Application via the Worker Portal** job aid.

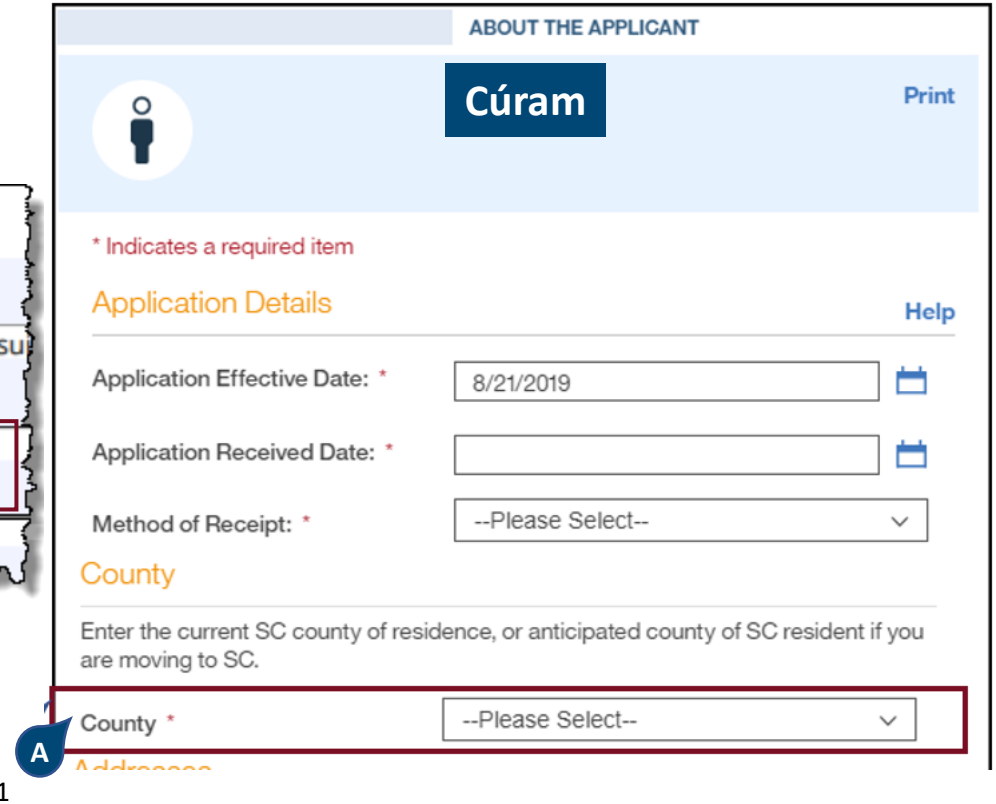
DESK REFERENCE FORMAT

The right-hand side of the page follows the screen-by-screen process for a Non-MAGI Application in Cúram. The left-hand side of the page highlights the corresponding section of Form 3400, 3400-01, 3400-A, 3400-B, or 3401. Blue markers match the question on the left to the question on the right (as shown in the County example below).

Form 3400



Cúram



Desk REFERENCE

Register Person Screen

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400

Primary contact person

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

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

E — 4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

F — 10. City | 11. State | 12. ZIP code | 13. County

G — 14. Phone number | 15. Other phone number

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address:

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

STEP 1: PERSON 1 Complete Step 1 for each person in your family. Start with information about yourself.

Complete Step 1 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See the instructions for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

B — 1. First name, Middle name, Last name, & Suffix | 2. Relationship to you? SELF

D — 3. Date of birth (mm/dd/yyyy) | 4. Sex: ☐ Male ☐ Female (C) | 5. Social Security number (SSN) (A) | a. If you don't have a SSN, have you applied for one? ☐ Yes ☐ No *If no, indicate the reason at question 15.*

Cúram

Register Person

1 Registered Person Check — 2 Registration

Step 2: Registration

A — Social Security Number | Title

First Name * | Middle Name

B — Last Name * | Suffix

Initials | Birth Last Name

Mother's Birth Last Name | Gender *

D — Date of Death (C)

Registration Date * 8/21/2019 | Preferred Office

Preferred Language | Preferred Communication

Private Address

E — Street 1 | Street 2

City | County

State | Zip

Mailing Address

Please enter a mailing address if different from private address.

F — Street 1 | Street 2

City | County

State | Zip

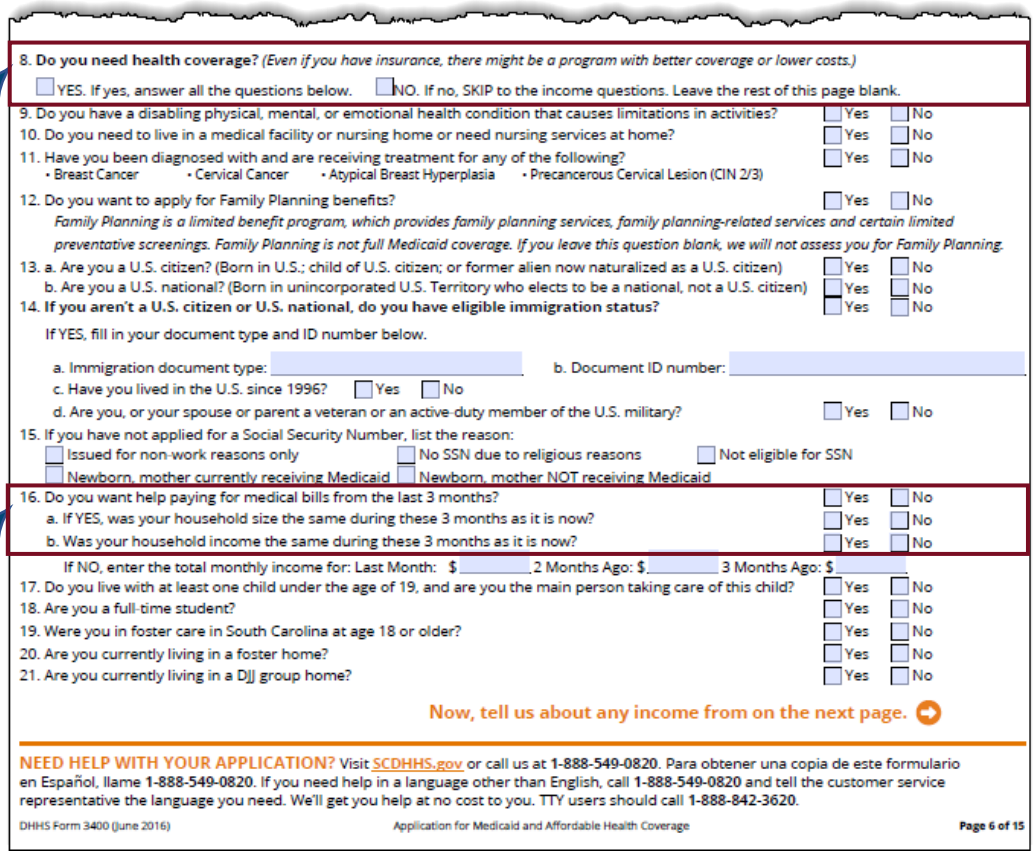
Phone Number

G — Type | Country Code

Area Code | Phone

Extension

Form 3400



8. **Do you need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*
☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions. Leave the rest of this page blank.

A

9. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
10. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
11. Have you been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)
12. Do you want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
13. a. Are you 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
b. Are you a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No
14. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in your document type and ID number below.
a. Immigration document type: _____ b. Document ID number: _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
15. If you have not applied for a Social Security Number, list the reason:
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid

B

16. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was your household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was your household 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: $_____
17. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No
18. Are you a full-time student? ☐ Yes ☐ No
19. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
20. Are you currently living in a foster home? ☐ Yes ☐ No
21. Are you currently living in a DJJ group home? ☐ Yes ☐ No

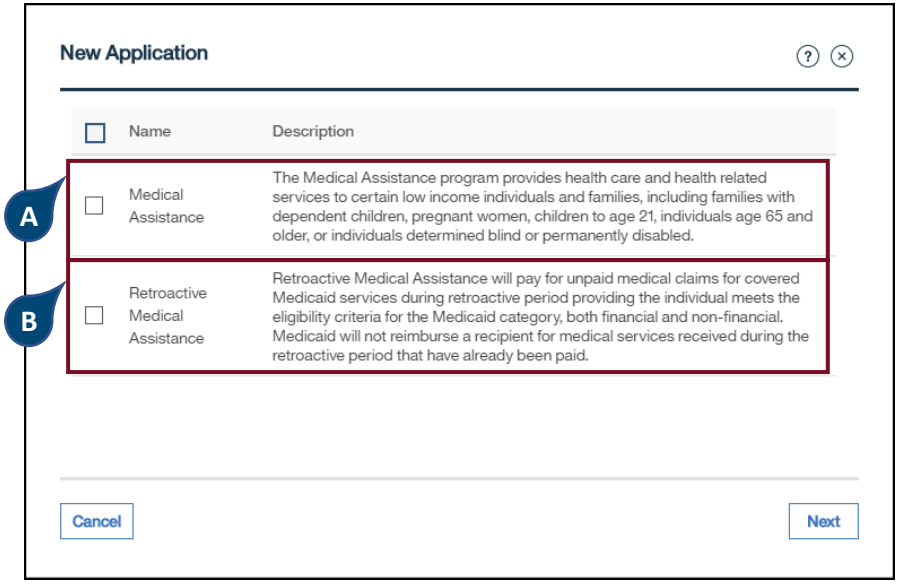
Now, tell us about any income from on the next page.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

DHHS Form 3400 (June 2016) Application for Medicaid and Affordable Health Coverage **Page 6 of 15**

B is also applicable on Page 14.

Cúram



New Application

	Name	Description
A ☐	Medical Assistance	The Medical Assistance program provides health care and health related services to certain low income individuals and families, including families with dependent children, pregnant women, children to age 21, individuals age 65 and older, or individuals determined blind or permanently disabled.
B ☐	Retroactive Medical Assistance	Retroactive Medical Assistance will pay for unpaid medical claims for covered Medicaid services during retroactive period providing the individual meets the eligibility criteria for the Medicaid category, both financial and non-financial. Medicaid will not reimburse a recipient for medical services received during the retroactive period that have already been paid.

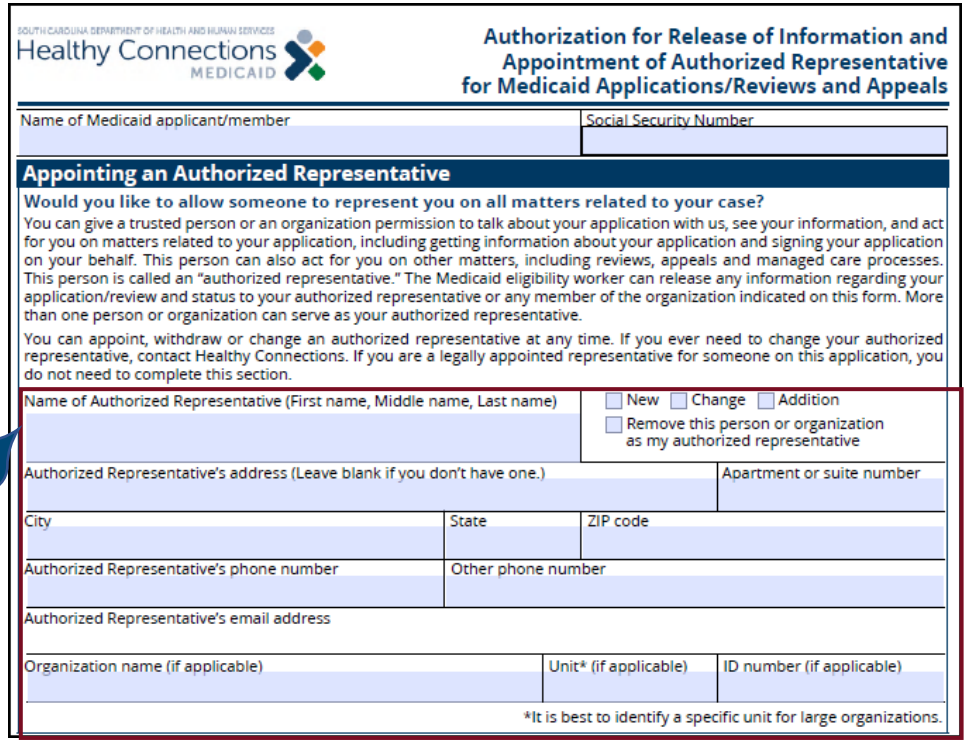
Cancel Next

Desk REFERENCE

Application Sponsor Code Screen (New Non-MAGI Application Wizard)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

DHHS Form 1282



Healthy Connections MEDICAID

Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

Name of Medicaid applicant/member | Social Security Number

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "authorized representative." The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

A

Name of Authorized Representative (First name, Middle name, Last name) | ☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative

Authorized Representative's address (Leave blank if you don't have one.) | Apartment or suite number

City | State | ZIP code

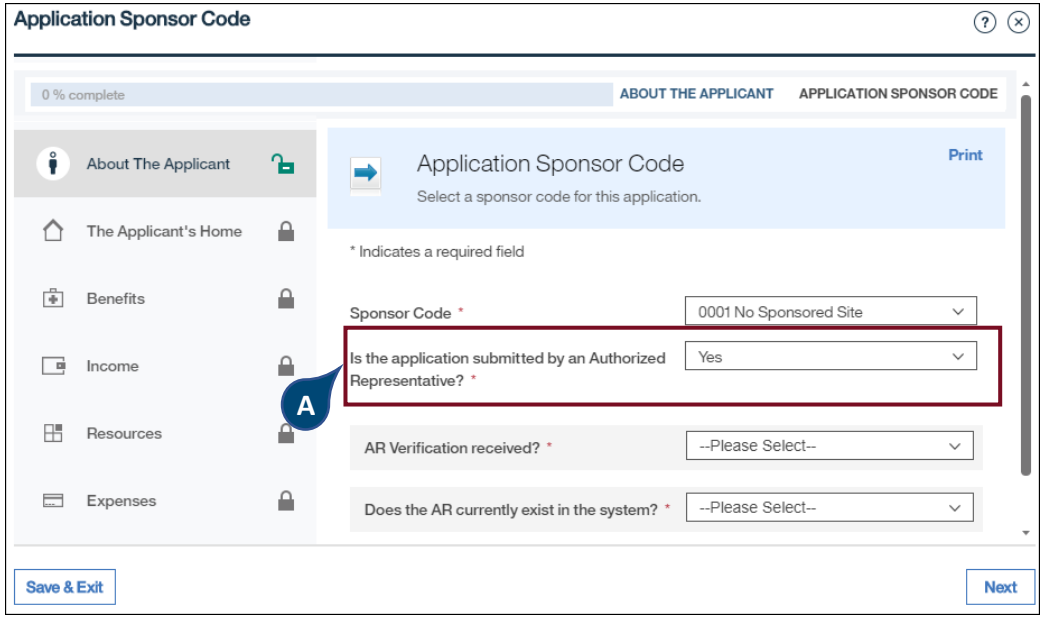
Authorized Representative's phone number | Other phone number

Authorized Representative's email address

Organization name (if applicable) | Unit* (if applicable) | ID number (if applicable)

*It is best to identify a specific unit for large organizations.

Cúram



Application Sponsor Code

0 % complete | ABOUT THE APPLICANT | APPLICATION SPONSOR CODE

- About The Applicant
- The Applicant's Home
- Benefits
- Income
- Resources
- Expenses

Application Sponsor Code — Print

Select a sponsor code for this application.

* Indicates a required field

Sponsor Code * : 0001 No Sponsored Site

A

Is the application submitted by an Authorized Representative? * : Yes

AR Verification received? * : --Please Select--

Does the AR currently exist in the system? * : --Please Select--

Save & Exit | Next

Desk REFERENCE

About the Applicant Screen (New Non-MAGI Application Wizard)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400

Primary contact person

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

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

A

8. Mailing address (if different from home address) | 9. Apartment or suite number

B

10. City | 11. State | 12. ZIP code | 13. County

C

14. Phone number | 15. Other phone number

D

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address:

E

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

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list dependents:

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the tax filer: How are you related to the tax filer?

7. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. What is your due date?

c. If recently pregnant, enter the date the pregnancy ended:

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

8. **Do you need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

F

☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions. Leave the rest of this page blank.

ABOUT THE APPLICANT

Cúram

Print

* Indicates a required item

Application Details Help

Application Effective Date: * 8/21/2019

Application Received Date: *

Method of Receipt: * --Please Select--

County

Enter the current SC county of residence, or anticipated county of SC resident if you are moving to SC.

A

County * --Please Select--

Addresses Help

B

Is the applicant's mailing address the same as the applicant's residential address? --Please Sele

Contact Details Help

C

Please provide a phone number or an email address if available.

Home Phone number: 803 6573451

Other:

D

Email Address:

Special Needs Help

E

What is the applicant's preferred communication language? English

People in applicant's Home Help

Are there any other people living in the home? * --Please Sele

Help paying for your benefits Help

F

Are you applying for benefits? * --Please Sele

Desk REFERENCE

Applicant Details Screen (New Non-MAGI Application Wizard)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400

STEP 1: PERSON 1 Complete Step 1 for each person in your family. Start with information about yourself.

Complete Step 1 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See the instructions for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix
2. Relationship to you? SELF
3. Date of birth (mm/dd/yyyy)
4. Sex: ☐ Male ☐ Female
5. Social Security number (SSN)

A — a. If you don't have a SSN, have you applied for one? ☐ Yes ☐ No *If no, indicate the reason at question 15.*

We need this if you want health coverage and have an SSN. Providing your SSN [illegible] helpful if you don't want health coverage since it can speed up the application process. We use SS[illegible]k income and [illegible]formatio[illegible]who's eligible for help with health

preventative screenings. Family Planning [illegible]Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

13. a. Are you 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
    b. Are you a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No
14. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** ☐ Yes ☐ No

B — If YES, fill in your document type and ID number below.

a. Immigration document type: _____ b. Document ID number: _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. If you have not applied for a Social Security Number, list the reason: ☐ [illegible] ☐ Not eli[illegible]

[illegible] Month

If NO, enter the total monthly income for: Last Month: $_____ 2 Months Ago: $_____ 3 Months Ago: $_____

17. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

D — 18. Are you a full-time student? ☐ Yes ☐ No

19. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

STEP 1: PERSON 1 (Continue with yourself)

C — 22. **If Hispanic/Latino, ethnicity (OPTIONAL)**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

23. **Race (OPTIONAL—check all that apply)**
☐ White ☐ Native Hawaiian ☐ Filipino ☐ Korean ☐ Black/African American ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Other Asian ☐ Samoan ☐ American Indian or Alaska native ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other: _____

Form 3400-A

[illegible] someone [illegible] am 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

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

Cúram

ABOUT THE APPLICANT | APPLICANT DETAILS

Applicant Details — Please enter the applicant's details. Print

* Indicates a required item

Personal Details Help

A — Does the applicant have an SSN? * --Please Select--

Help

Marital Status: * --Please Select--

Help

B — What is the applicant's citizen status? * --Please Select--

Help

When did the applicant become a member of the household? *

Where The Person Lives Help

Is the applicant a resident of this state? * --Please Select--

Help

E — What is the applicant's living arrangement? * --Please Select--

What is the status of this living arrangement? * --Please Select--

When did this living arrangement begin? *

Race and Ethnicity Help

Please check the boxes to tell us about the applicant's race and/or ethnicity. These questions are for statistical purposes only. The applicant's responses will not affect the applicant's application.

C — Black or African American ☐

Education Help

D — Does the applicant currently attend high school, college, vocational or technical school? --Please Select--

Desk REFERENCE

Applicant Details Screen (New Non-MAGI Application Wizard)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3401

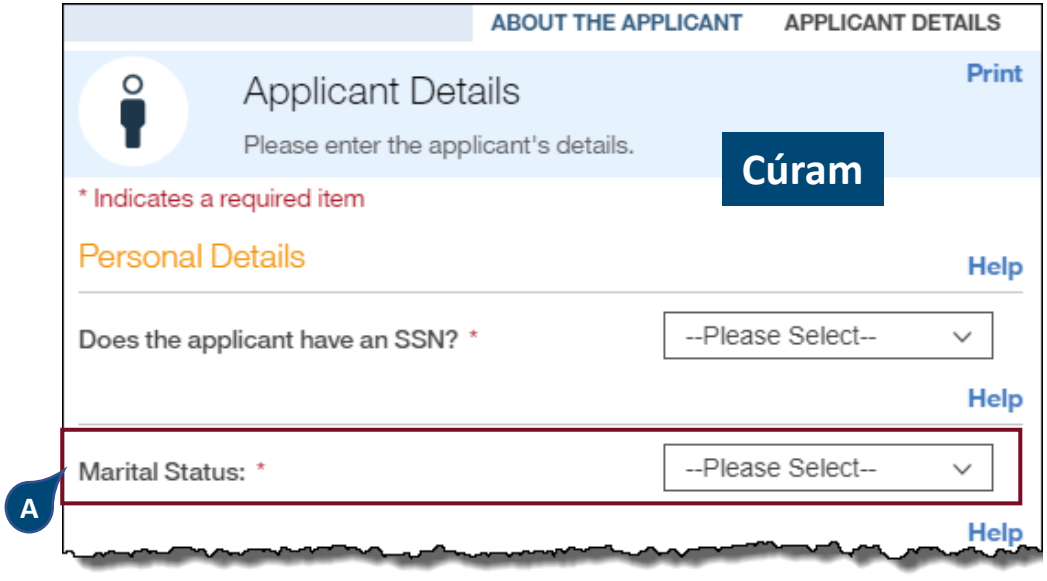
2. **Tell us about the person(s) who needs nursing home, long term care, or residential care. Please include any dependents the person may have, such as a spouse or children.**

This information is Optional for:
- Anyone not applying for Medicaid coverage;
- A non-citizen applying for Emergency Services Only

	Name	Relationship to the Applicant * (Use Relationship Codes shown below)	Marital Status Single, Married, Divorced, Widowed, Seperated	Date of Birth	Sex	Is this person applying for Medicaid?	**See below Is this person applying for Family Planning?	Social Security Number	Race *** (Race codes shown below)	Is this person a US citizen?
1.	Applicant		A		☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
2.	Spouse				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
3.					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
4.					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
5.					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No

* Relationship Codes: SP Spouse; BF/GF Boyfriend/Girlfriend; NR Not Related; OTH Other; CH Child (Natural or Adopted); SC Step-Child; GC Grandchild; NE Niece/Nephew

*** Race Codes: 01 White/Caucasian; 02 Black/African American; 03 Multi Race; 04 Federally Recognized Native American *(Requires Verification)*; 05 Other Native American; 06 Alaska Native; 07 Asian; 08 Other/Unknown; 09 Native Hawaiian/Pacific Islander; 10 Hispanic



Desk REFERENCE

Home Member Information Screen

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400

STEP 1: PERSON 2

Complete Step 1 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See the instructions for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

A 1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

D 3. Date of birth (mm/dd/yyyy)

E 4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if PERSON 2 wants health coverage and has an SSN.

a. If you don't have a SSN, have you applied for one? ☐ Yes ☐ No
If no, indicate the reason at question 16.

B 6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Does Person 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.
a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:
b. Will Person 2 claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list dependents:
c. Will Person 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the tax filer: How are you related to the tax filer?
8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. What is your due date?
c. If recently pregnant, enter the date the pregnancy ended:
d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

C 9. **Does PERSON 2 need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs)*
☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions. Leave the rest of this page blank.

THE APPLICANT'S HOME | HOME MEMBER INFORMATION

Home Member Information — **Cúram** — Print

Please enter the details about the next person in the applicant's home.

Earl — Person 2

* Indicates a required field

Person Details — Help

A First Name: *
Middle Name:
Last Name: *
Suffix: --Please Select--

B Is your address same as Primary Client's address?: * --Please Select--

C Is this household member also applying? * --Please Select--

Help

D Date of Birth: *
Date of Death:

E Gender: * --Please Select--
Marital Status: * --Please Select--

Help

When did this member become a member of the household? *

Desk REFERENCE

Home Member Information Screen (Continued)

Form 3400

9. **Does PERSON 2 need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs)*
☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions. Leave the rest of this page blank.

10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
11. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
12. Have you been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)
13. Does PERSON 2 want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
14. a. Is PERSON 2 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
b. Is PERSON 2 a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No
15. **If PERSON 2 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in PERSON 2's document type and ID number below.
a. Immigration document type: _____ b. Document ID number: _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
16. If you have not applied for a Social Security Number, list the reasons
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid
17. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was this person's household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was this person's household 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: $_____
18. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No
B 19. Is PERSON 2 a full-time student? ☐ Yes ☐ No
20. Was PERSON 2 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
21. Is PERSON 2 currently living in a foster home? ☐ Yes ☐ No
22. Is PERSON 2 currently living in a DJJ group home? ☐ Yes ☐ No

Now, tell us about any income from PERSON 2 on the next page.

STEP 1: PERSON 2

A 23. **If Hispanic/Latino, ethnicity (OPTIONAL)**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other: _____

24. **Race (OPTIONAL—check all that apply)**
☐ White ☐ Native Hawaiian ☐ Filipino ☐ Korean ☐ Black/African American
☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Other Asian
☐ Samoan ☐ American Indian or Alaska native ☐ Guamanian or Chamorro
☐ Other Pacific Islander ☐ Other: _____

Cúram

Where the Person Lives Help

Is the person a resident of this state? * --Please Select--

Help

What is the applicant's living arrangement? --Please Select--

What is the status of this living arrangement? --Please Select--

When did this living arrangement begin? [ ]

Race and Ethnicity Help

A Please check the boxes to tell us about this person's race and/or ethnic origin. These questions are for statistical purposes only and the person does not have to answer them.

Black or African American ☐
American Indian or Alaskan Native ☐
Asian ☐
Hawaiian or Pacific Islander ☐

Optional

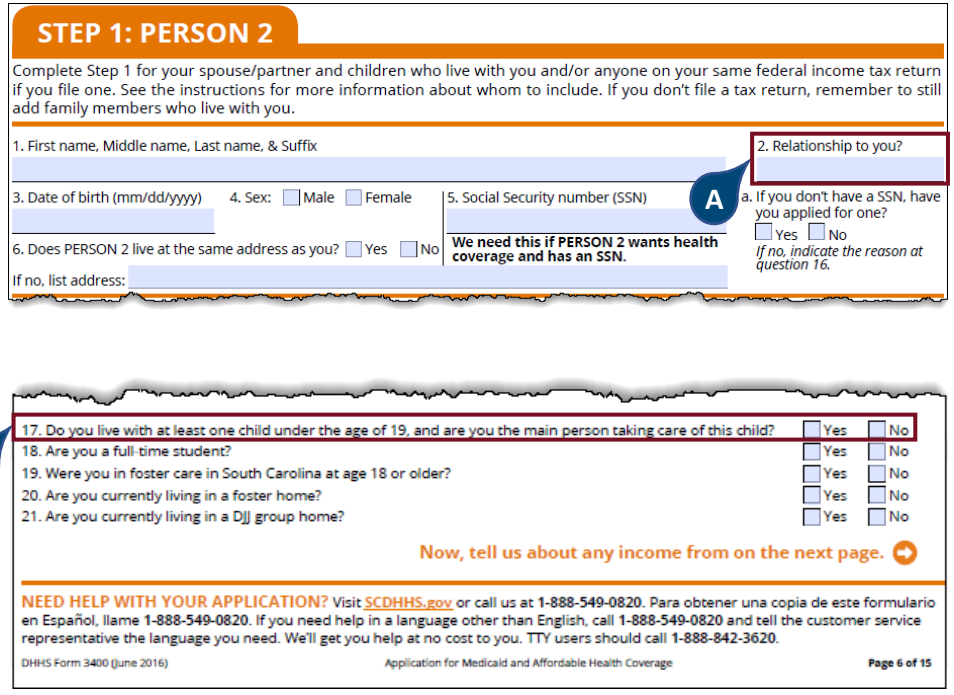
Education Help

B Does the applicant currently attend high school, college, vocational or technical school? --Please Select--

Additional Household Members Help

Are there more people in the home? * --Please Select--

Form 3400



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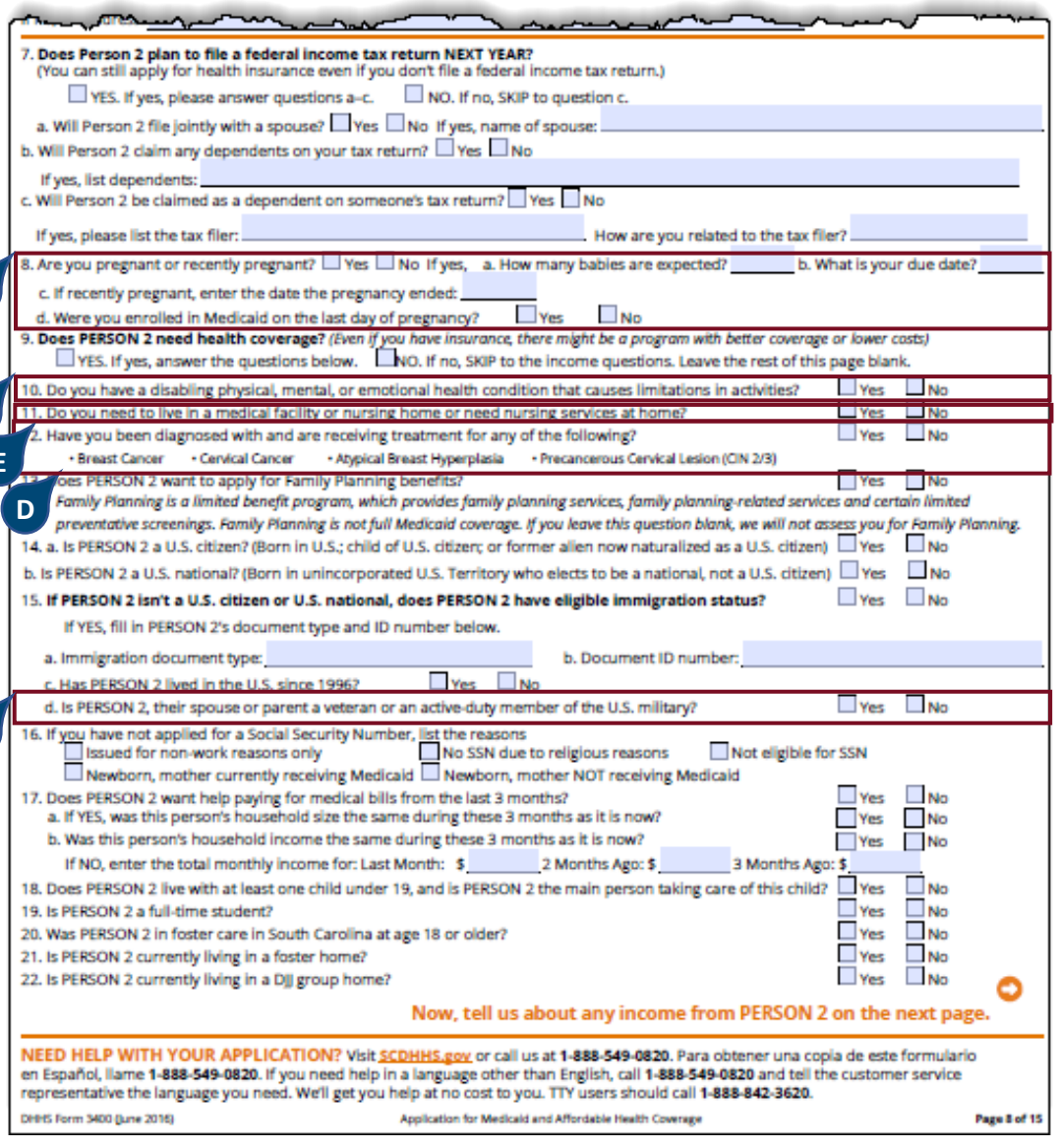
Form 3400



7. **Does Person 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.
a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:
b. Will Person 2 claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list dependents:
c. Will Person 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the tax filer: How are you related to the tax filer?

B 8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. What is your due date?
c. If recently pregnant, enter the date the pregnancy ended:
d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. **Does PERSON 2 need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs)*
☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions. Leave the rest of this page blank.

A 10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
11. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
E 12. Have you been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)
D 13. Does PERSON 2 want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
14. a. Is PERSON 2 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
b. Is PERSON 2 a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No
15. **If PERSON 2 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in PERSON 2's document type and ID number below.
a. Immigration document type: b. Document ID number:
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
C d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
16. If you have not applied for a Social Security Number, list the reasons
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid
17. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was this person's household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was this person's household 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: $
18. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No
19. Is PERSON 2 a full-time student? ☐ Yes ☐ No
20. Was PERSON 2 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
21. Is PERSON 2 currently living in a foster home? ☐ Yes ☐ No
22. Is PERSON 2 currently living in a DJJ group home? ☐ Yes ☐ No

Now, tell us about any income from PERSON 2 on the next page.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

DHHS Form 3400 (June 2016) Application for Medicaid and Affordable Health Coverage **Page 8 of 15**

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THE APPLICANT'S HOME GENERAL INFORMATION

General Information

Print

These questions are general questions about the applicant and the people in the applicant's home. Please answer as many questions as the applicant can.

* Indicates a required item

General Information Help

Is anyone in the applicant's home blind? * --Pl

Help

A Is anyone disabled? * --Pl

Help

B Is anyone pregnant? * --Pl

Help

C Does anyone have military status? * --Pl

Help

D Has anyone in the applicant's home been diagnosed with and are receiving treatment for any of the following? Breast Cancer, Cervical Cancer or Precancerous Conditions. * --Pl

Help

E Does applicant or someone in applicant's home is applying for want nursing home services, either in a nursing home or at home? * --Pl

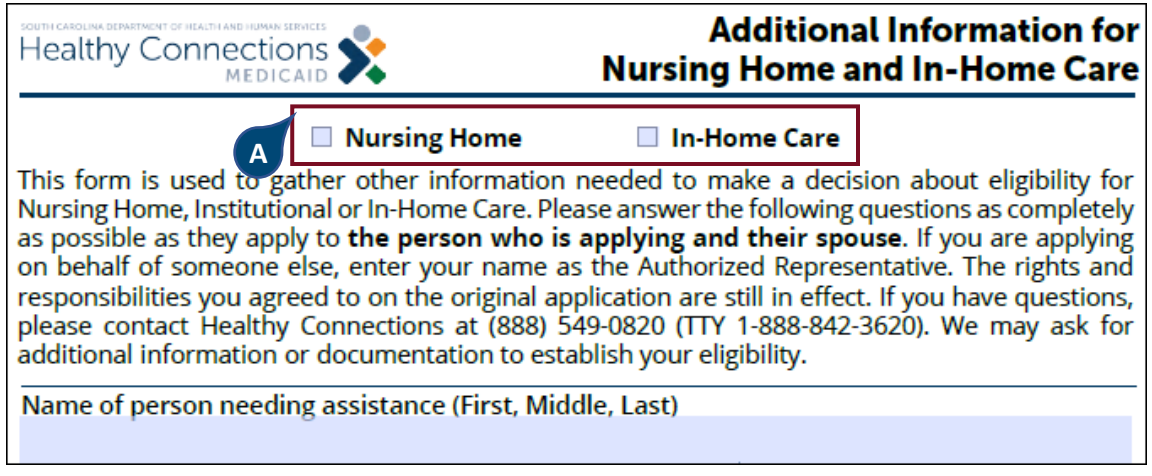
Help

Does applicant or someone in applicant's home is applying for want to go into a Residential Care Facility/Boarding Home? * --Pl

Help

Does applicant or someone in applicant's home is applying for currently in a Hospital, Nursing Home, or Residential Care Facility? * --Pl

Form 3400-B



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

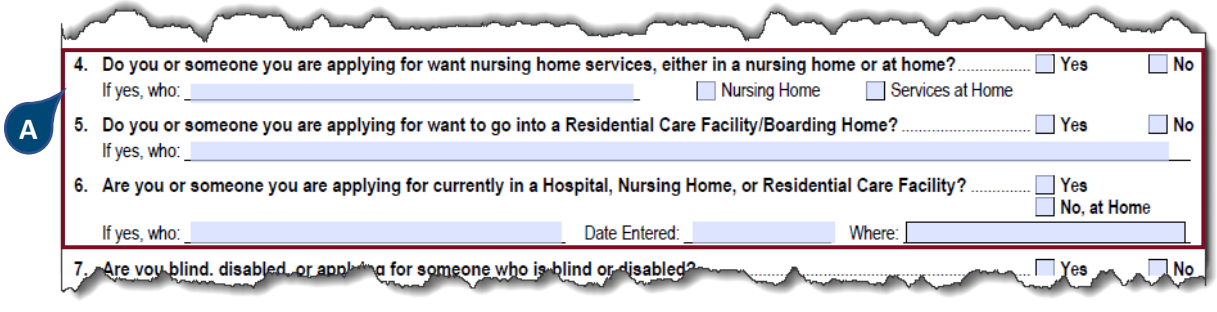
Additional Information for Nursing Home and In-Home Care

A ☐ 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)

Form 3401



A

4. Do you or someone you are applying for want nursing home services, either in a nursing home or at home? ☐ Yes ☐ No
   If yes, who: _____ ☐ Nursing Home ☐ Services at Home
5. Do you or someone you are applying for want to go into a Residential Care Facility/Boarding Home? ☐ Yes ☐ No
   If yes, who: _____
6. Are you or someone you are applying for currently in a Hospital, Nursing Home, or Residential Care Facility? ☐ Yes ☐ No, at Home
   If yes, who: _____ Date Entered: _____ Where: _____
7. Are you blind, disabled, or applying for someone who is blind or disabled? ☐ Yes ☐ No

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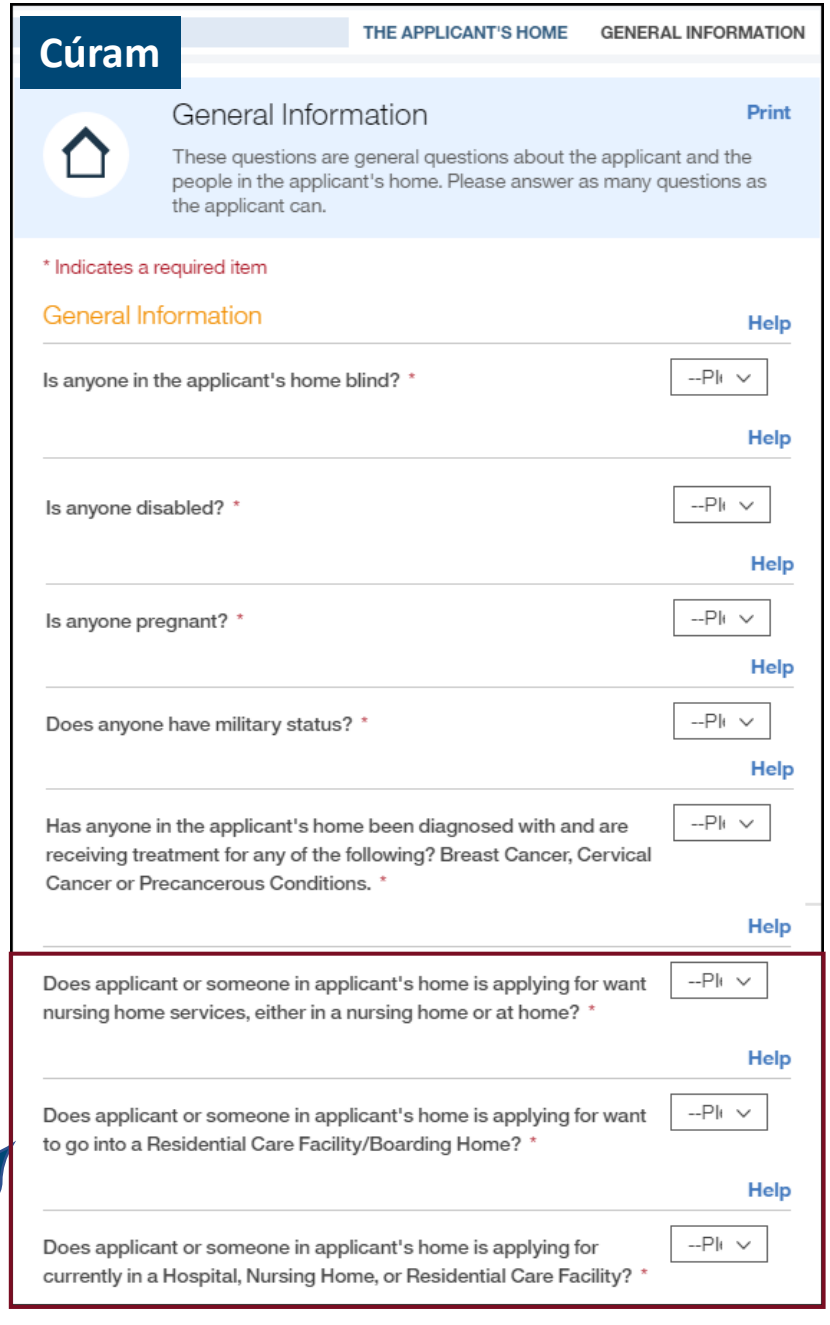


THE APPLICANT'S HOME GENERAL INFORMATION

General Information — Print

These questions are general questions about the applicant and the people in the applicant's home. Please answer as many questions as the applicant can.

* Indicates a required item

General Information — Help

Is anyone in the applicant's home blind? * --Pl

Help

Is anyone disabled? * --Pl

Help

Is anyone pregnant? * --Pl

Help

Does anyone have military status? * --Pl

Help

Has anyone in the applicant's home been diagnosed with and are receiving treatment for any of the following? Breast Cancer, Cervical Cancer or Precancerous Conditions. * --Pl

Help

A

Does applicant or someone in applicant's home is applying for want nursing home services, either in a nursing home or at home? * --Pl

Help

Does applicant or someone in applicant's home is applying for want to go into a Residential Care Facility/Boarding Home? * --Pl

Help

Does applicant or someone in applicant's home is applying for currently in a Hospital, Nursing Home, or Residential Care Facility? * --Pl

Form 3400-A

2. Most forms of income we need to know about are on your application. Please check if you or someone in your household has any of the following types of income and tell us about that income in the table below.

☐ Child Support ☐ Money From Friends and Relatives

☐ Veterans Assistance ☐ Workers Comp/Long Term or Short Term Disability

	Income Source/Type	How Often Received	Amount Received
a. Person Receiving Money			
b. Person Receiving Money			
c. Person Receiving Money			
d. Person Receiving Money			

A

Form 3400

Current job & income information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 24.
☐ **Not Employed** SKIP to question 36.
☐ **Self-Employed** SKIP to question 35.

B

CURRENT JOB 1:

24. Employer name and address
25. Employer phone number

B

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ 27. Average hours worked each week 28. Start date

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

29. Employer name and address
30. Employer phone number

Cúram

BENEFITS BENEFIT INFORMATION

Benefit Information

Print

We need to know a little about benefits the applicant may currently receive or has received in the past. Please answer the questions below.

* Indicates a required item

Benefit Information Help

Is the applicant or anyone who lives with the applicant currently receiving benefits? * --Pl

Help

Has the applicant or anyone the applicant lives with previously received benefits in this or another state? * --Pl

A

INCOME EMPLOYMENT INFORMATION

Employment Information

Print

Please tell us about the people in the applicant's home who have jobs or are self-employed.

* Indicates a required item

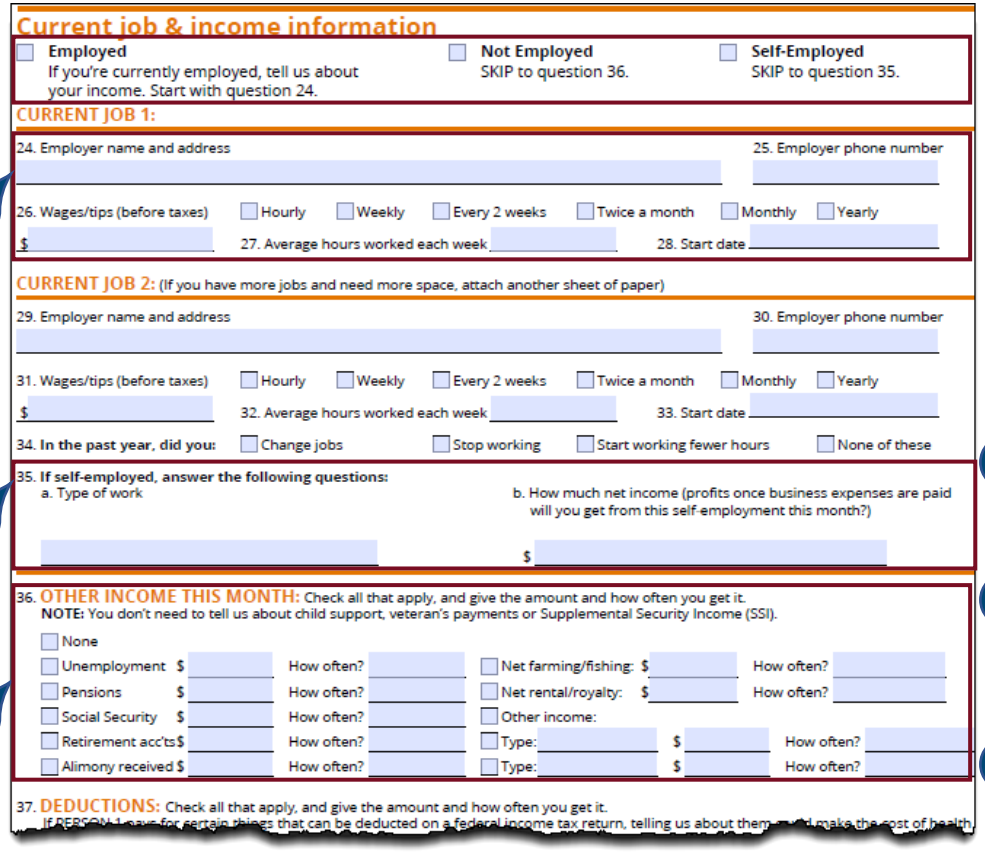
Employment Information Help

Does anyone in the applicant's home have a job? * --Pl

Is anyone in the applicant's home self-employed? * --Pl

B

Form 3400



Current job & income information

☐ **Employed** — If you're currently employed, tell us about your income. Start with question 24.
☐ **Not Employed** — SKIP to question 36.
☐ **Self-Employed** — SKIP to question 35.

CURRENT JOB 1:

24. Employer name and address
25. Employer phone number

A

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ 27. Average hours worked each week 28. Start date

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

29. Employer name and address
30. Employer phone number

31. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ 32. Average hours worked each week 33. Start date

34. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

B

35. **If self-employed, answer the following questions:**
a. Type of work
b. How much net income (profits once business expenses are paid will you get from this self-employment this month?)
$

C

36. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ How often?
☐ Pensions $ How often?
☐ Social Security $ How often?
☐ Retirement acc'ts $ How often?
☐ Alimony received $ How often?
☐ Net farming/fishing: $ How often?
☐ Net rental/royalty: $ How often?
☐ Other income:
☐ Type: $ How often?
☐ Type: $ How often?

37. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health

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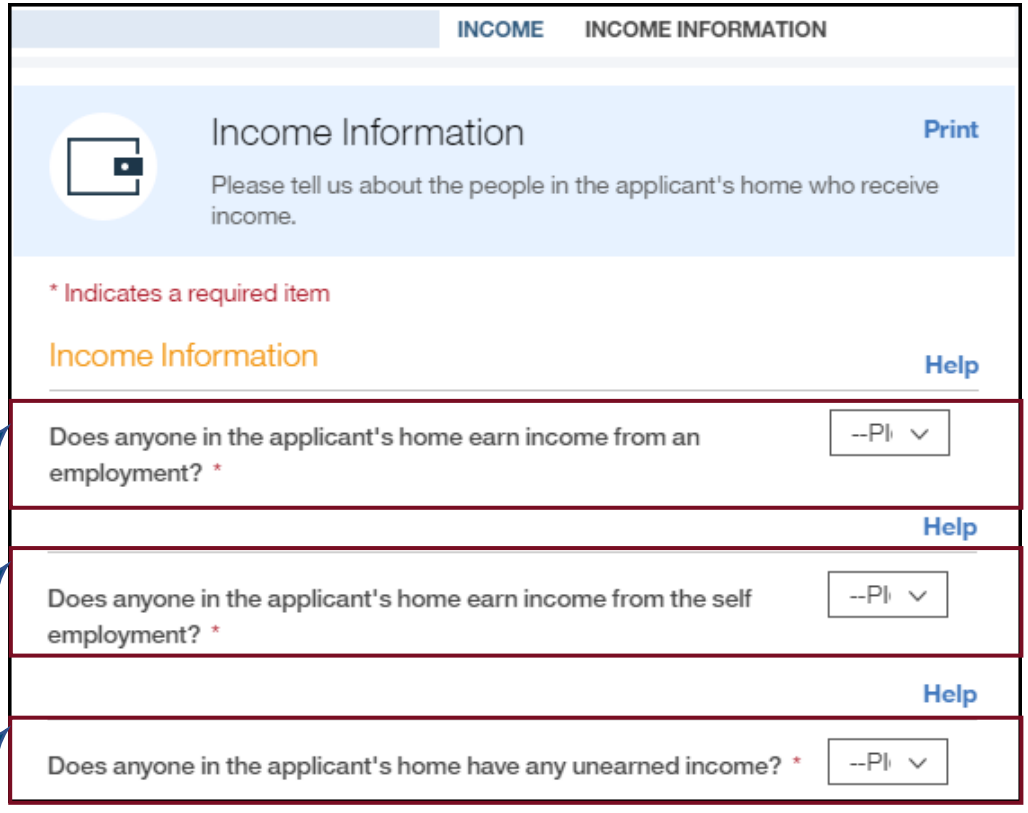


INCOME INCOME INFORMATION

Income Information — Print

Please tell us about the people in the applicant's home who receive income.

* Indicates a required item

Income Information — Help

A

Does anyone in the applicant's home earn income from an employment? * --Pl

Help

B

Does anyone in the applicant's home earn income from the self employment? * --Pl

Help

C

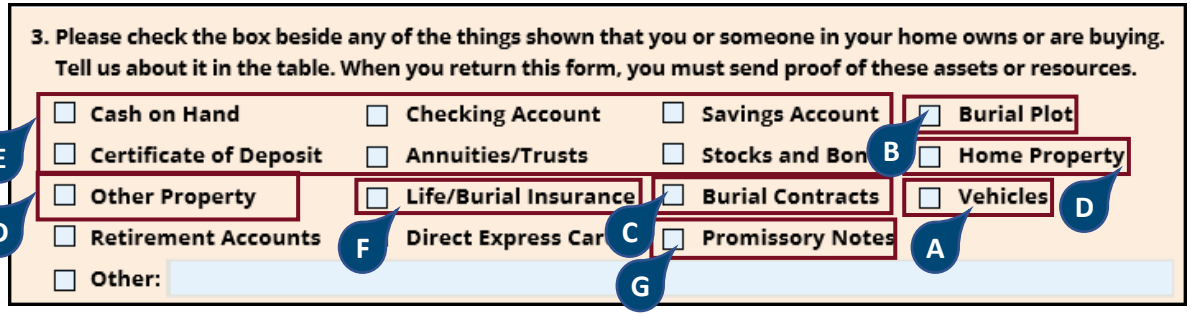
Does anyone in the applicant's home have any unearned income? * --Pl

Desk REFERENCE

Resource General Information Screen

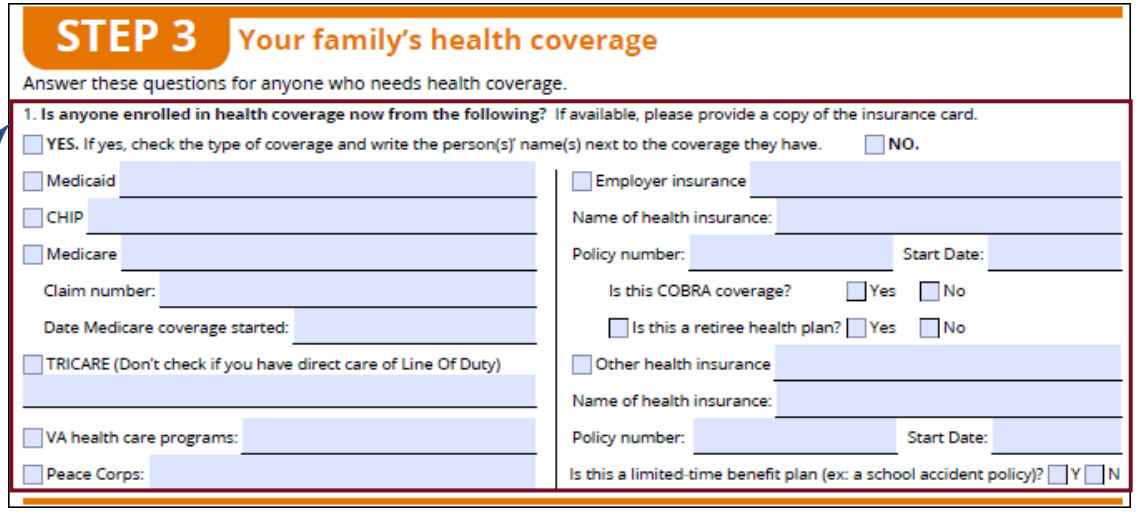
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400-A



Resources

Form 3400



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Desk REFERENCE

Resource General Information Screen

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3401

A

21. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years? ☐ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received

Form 3400-B

A

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
$	$

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RESOURCES | RESOURCE GENERAL INFORMATION

Resource General Information — Print

Please tell us about the people in the applicant's home who have resources.

* Indicates a required item

Resources Information — Help

Does anyone in the applicant's home have a vehicle? * --Pl

Help

Does anyone in the applicant's home have a burial space? * --Pl

Help

Does anyone in the applicant's home have a burial plan? * --Pl

Help

Does anyone in the applicant's home have property? * --Pl

Help

Does anyone in the applicant's home have liquid resources? * --Pl

Help

Does anyone in the applicant's home have life insurance? * --Pl

Help

Did anyone in the household loan money? * --Pl

Help

Does anyone in the applicant's home have medical insurance? * --Pl

Is anyone in the applicant's home a grantor, beneficiary or trustee of a trust? * --Pl

Is anyone in the applicant's home a beneficiary, owner or annuitant of an annuity? * --Pl

Has anyone in the applicant's home sold, traded, given away or transferred a resource in the last 60 months/5 years? * --Pl

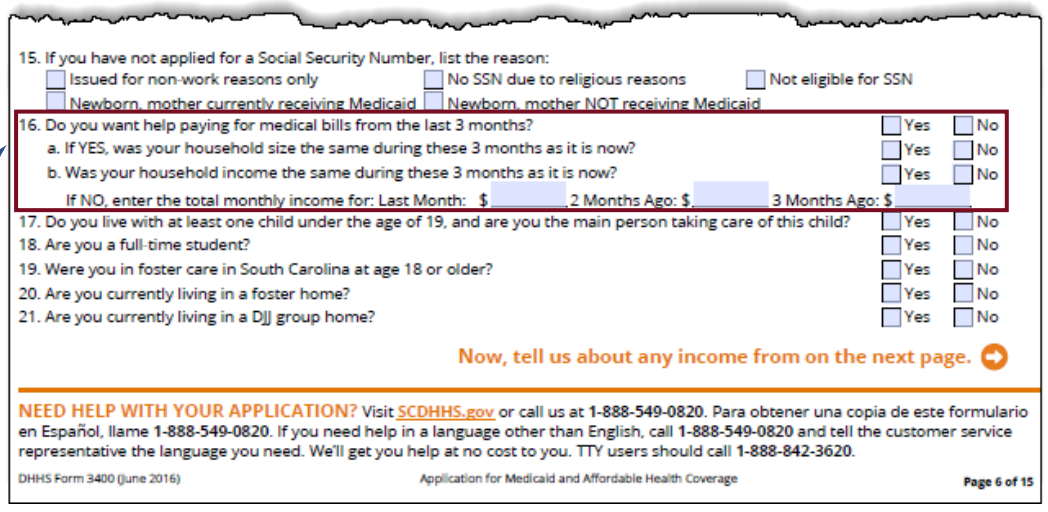
A

Desk REFERENCE

Expenses Information

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400



15. If you have not applied for a Social Security Number, list the reason:
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid

A

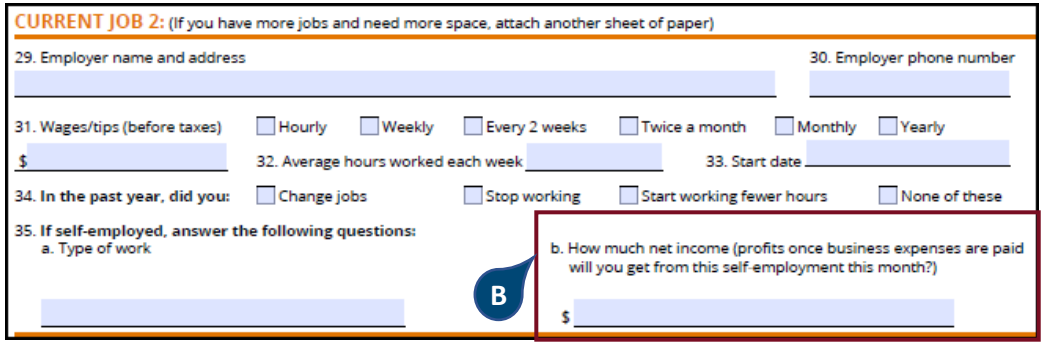
16. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was your household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was your household income the same during these 3 months as it is now? ☐ Yes ☐ No
If NO, enter the total monthly income for: Last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

17. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No
18. Are you a full-time student? ☐ Yes ☐ No
19. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
20. Are you currently living in a foster home? ☐ Yes ☐ No
21. Are you currently living in a DJJ group home? ☐ Yes ☐ No

Now, tell us about any income from on the next page.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-888-842-3620.

DHHS Form 3400 (June 2016) Application for Medicaid and Affordable Health Coverage Page 6 of 15



CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

29. Employer name and address
30. Employer phone number

31. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$
32. Average hours worked each week
33. Start date

34. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

35. If self-employed, answer the following questions:
a. Type of work

B

b. How much net income (profits once business expenses are paid will you get from this self-employment this month?)
$

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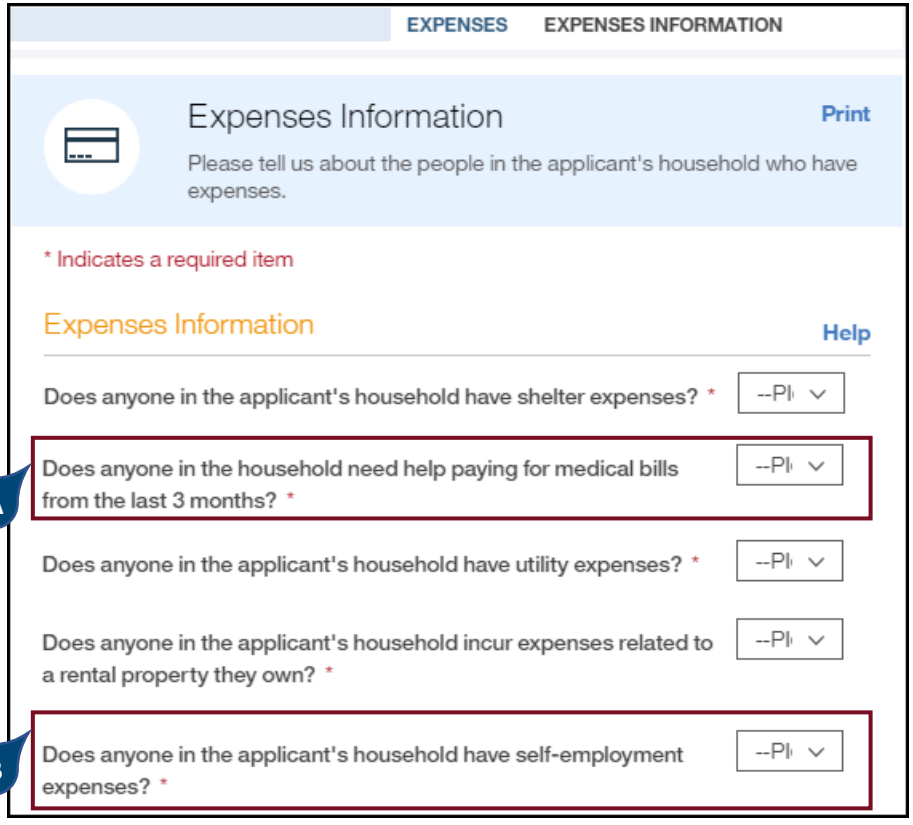


EXPENSES EXPENSES INFORMATION

Expenses Information Print

Please tell us about the people in the applicant's household who have expenses.

* Indicates a required item

Expenses Information Help

Does anyone in the applicant's household have shelter expenses? * --Pl

A

Does anyone in the household need help paying for medical bills from the last 3 months? * --Pl

Does anyone in the applicant's household have utility expenses? * --Pl

Does anyone in the applicant's household incur expenses related to a rental property they own? * --Pl

B

Does anyone in the applicant's household have self-employment expenses? * --Pl

Desk REFERENCE

Clients Rights & Responsibilities Screen

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form 3400-A

STEP 4 — **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.

K

C 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.

A 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.

D 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 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.

E 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.

F 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, the Department of Health and Human Services 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.

G 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.

H 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.

I 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 written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.

J 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.

B **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 cove

Cúram

Clients Rights & Responsibilities

* required field

I know that if Medicaid pays for a medical expense, any money I get from other health insurance or legal settlements will go to Medicaid in an amount equal to what Medicaid pays for the expense.

☐ Confirmed that the client agrees to adhere to this policy.

A 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.

☐ Confirmed that the client agrees to adhere to this policy.

B I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, SCDHHS and/or the Marketplace will use income data including information from tax returns of household members. This will determine yearly eligibility for help paying for health insurance for up to the next 5 years. SCDHHS and/or the Marketplace will send me a notice and let me make changes. If I don't, my eligibility will continue at the level indicated by the data. I understand this renewal process will occur each year for the next 5 years unless I tell SCDHHS and/or the Marketplace that I don't want to renew, or if I leave the Marketplace. I also understand that I can change my answer later. If I don't check the box, I can select less than 5 years.

☐ Confirmed that the client agrees to this renewal policy

C 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 visiting www.hhs.gov/ocr/office/file.

D 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 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.

E 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.

F As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery: 1) A person of any age who was a patient in a nursing facility, intermediate care facility for the mentally retarded, 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 2) 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 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.

G I know that I must tell SCDHHS 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.

H 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 our 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.

I If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid and CHIP programs, 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 review of the action. I must submit a written request for such a hearing to SCDHHS. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

J 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).

By selecting the box I state that I have read and agree to the rights and responsibilities stated on this page.

☐ Confirmed that the client agrees to report changes *

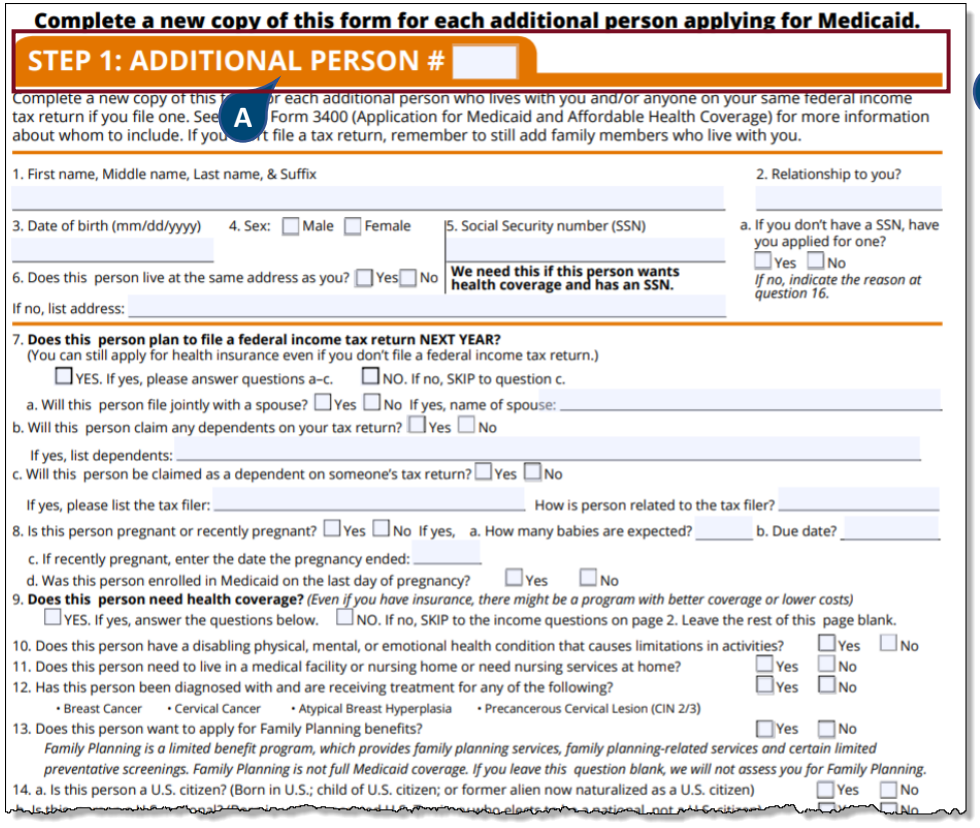
K Sign this application. The primary applicant should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in the application. I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty under federal law.

☐ Confirmed that the client has read or been made aware of the penalty of perjury *

FORM 3400-01

When a member is added to the household after an application is submitted, the information on Form 3400-01 is entered into Cúram using the Add a Member Wizard (Guided Change). This wizard is accessible on the Non-MAGI Application or Income Support Case. Further details can be found in the **Add a Member (Guided Change)** job aid.

Form 3400-01



Complete a new copy of this form for each additional person applying for Medicaid.

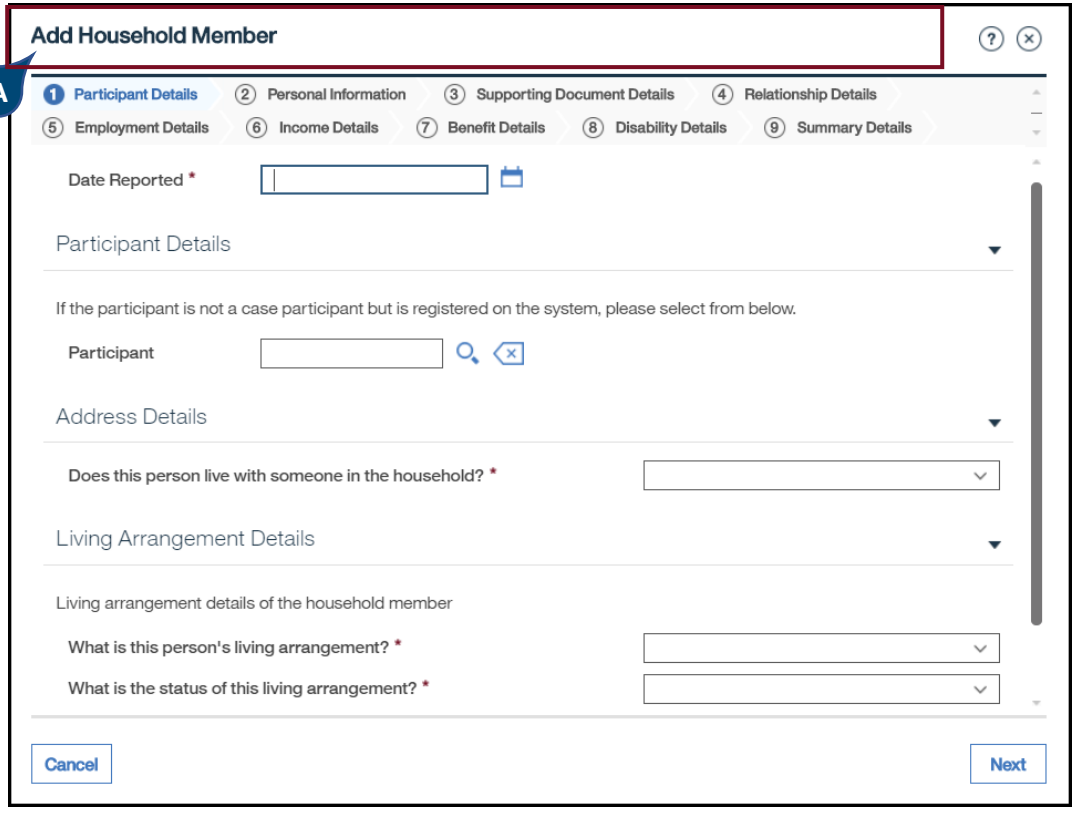
STEP 1: ADDITIONAL PERSON #

A

Complete a new copy of this f or each additional person who lives with you and/or anyone on your same federal income tax return if you file one. See Form 3400 (Application for Medicaid and Affordable Health Coverage) for more information about whom to include. If you t file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix
2. Relationship to you?
3. Date of birth (mm/dd/yyyy)
4. Sex: ☐ Male ☐ Female
5. Social Security number (SSN) — **We need this if this person wants health coverage and has an SSN.**
a. If you don't have a SSN, have you applied for one? ☐ Yes ☐ No *If no, indicate the reason at question 16.*
6. Does this person live at the same address as you? ☐ Yes ☐ No
If no, list address:
7. **Does this person plan to file a federal income tax return NEXT YEAR?** (You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.
a. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:
b. Will this person claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list dependents:
c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the tax filer: How is person related to the tax filer?
8. Is this person pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. Due date?
c. If recently pregnant, enter the date the pregnancy ended:
d. Was this person enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No
9. **Does this person need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs)*
☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions on page 2. Leave the rest of this page blank.
10. Does this person have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
11. Does this person need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
12. Has this person been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)
13. Does this person want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
14. a. Is this person 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

Add a Member Wizard (Guided Change)



CÚRAM QUESTIONS IN THE NON-MAGI APPLICATION WIZARD NOT FOUND IN FORM 3400 OR 3400-A

- What is the application sponsor code?
- Application Effective Date
- Application Received Date
- When did the applicant become a member of the household?
- What is the status of this living arrangement?
- When did this living arrangement begin?
- Relationship Start Date?
- Does anyone in the applicant's household have shelter expenses?
- Does anyone in the applicant's household have utility expenses?
- Does anyone in the applicant's household incur rental expenses related to property they own?

FORM 3400 OR 3400-A QUESTIONS NOT FOUND IN THE CÚRAM NON-MAGI APPLICATION WIZARD

3400

- Question 6 - Do you plan to file a federal income tax return NEXT YEAR? (for MAGI determination only)
- Question 12 – Do you want to apply for family planning benefits (for MAGI determination only)
- Question 19 – Were you in foster care in South Carolina at age 18 or older? (for MAGI determination only)
- Question 20 – Are you currently living in a foster home? (for MAGI determination only)
- Question 21 – Are you currently living in a DJJ group home? (for MAGI determination only)

3400-A

- Question 5 - Name of correctional facility and additional question 6 and 7

Most Recent Changes to this PowerPoint Presentation

Date	Description of Change
01/29/2020	Initial presentation created.