



## About this program

- Uninsured individuals may use this application to apply for Medicaid coverage in order to cover costs associated with COVID-19 diagnostic testing.
- Services covered are limited to those necessary for diagnostic testing for the COVID-19 virus.
- If you would like to apply for full Medicaid benefits, please request a DHHS Form 3400, Application for Healthy Connections (Medicaid) by calling (800) 549-0820 or apply online at [SCDHHS.gov](https://www.scdhhs.gov).



## What you may need to apply

- Social Security Number (or document numbers if lawfully present)



## Why do we ask for this information?

We ask for this 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, go to [SCDHHS.gov](https://www.scdhhs.gov).



## What happens next?

Send your complete, signed application by mail, email or fax. This information is listed at the end of the application. You will get instructions on the next steps to complete your application for COVID-19 testing. If you have questions, call 1-888-549-0820.



## Who can use this application?

- Any person who does not have current health insurance coverage.
- Applying will not affect your immigration status or your chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete DHHS Form 1282 - Authorized Representative, which is included at the end of this application.



## Get help with this application

- **Online:** [SCDHHS.gov](https://www.scdhhs.gov)
- **Phone:** Call our Member Contact Center at **1-888-549-0820**.

things to know

## 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](mailto: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).**

إذا كانت لغتك الأساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجاناً. اتصل على الرقم:  
**888-549-0820 (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 na ko thei.**

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

ဟံသုင်ဟံသး- နမ့ကတိံ ကညီ ကျိင်အယိ, နမ့န့ၢ် ကျိင်အတၢ်မၤစၢၤလၢ တလၢကတၢ်လၢကတၢ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး  
1-888-549-0820 (TTY: 1-888-842-3620).

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

သတိပြုရန် - အကယ်၍ သင့်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။  
ဖုန်းနံပါတ် 1-888-549-0820 (TTY: 1-888-842-3620) သို့ ခေါ်ဆိုပါ။

# STEP 1

Date \_\_\_\_\_

We need one adult in the family to be the primary contact person for your application. This can be the person applying for coverage for themselves and/or can be a person applying for a family member. We keep all information private and secure, as required by law. We use personal information only to check eligibility for health coverage. If you need to add additional people to this application, make blank copies of page 4 to add them. You are not required to provide immigration status or a Social Security Number (SSN) for the primary contact person if that person does not need health coverage.

## 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/suite number

4. City

5. State

6. ZIP code

7. County

8. Mailing address (if different from home address)

9. Apartment/suite number

10. City

11. State

12. ZIP code

13. County

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)?

18. Gender

19. Date of Birth (mm/dd/yyyy)

Male

Female

## Is someone helping you fill out this application?

Complete the following section if you are filling out this form on behalf of the primary contact person and/or applicant(s). Otherwise, leave blank.

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

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

22. Organization Name (if applicable)

**NEED HELP WITH YOUR APPLICATION?** Visit [SCDHHS.gov](https://www.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**.

# STEP 1

## Information about person needing coverage

If you are the primary contact person completing this section for yourself, enter "Self" for Question 24.

23. First name, Middle name, Last name, & Suffix \_\_\_\_\_

24. Relationship to Primary Contact? \_\_\_\_\_

25. Date of birth (mm/dd/yyyy) \_\_\_\_\_

26. Sex:  Male  Female

27. Social Security number (SSN) \_\_\_\_\_

We need a SSN if this person wants health coverage and has an SSN. We use SSNs to check information to see who's eligible to receive help with health coverage costs related to COVID-19. If you want help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). TTY users should call 1-888-842-3620.

28. a. Are you a U.S. citizen?  Yes  No

(Born in U.S., child of U.S. citizen, or former alien now naturalized as a U.S. citizen)

b. Are you a U.S. national?  Yes  No

(Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen)

If you answered YES to Question 28 a. or b., SKIP to Question 30.

29. If you aren't a U.S. citizen or national, check here if you have eligible immigration status.

Enter your document type and ID number below. You can also include other immigration-related information in 29.c. If you do not have this information with you, you can still submit the application and we will contact you for any other information we need. This will not hold up the processing of your application.

a. Immigration document type: \_\_\_\_\_

b. Document ID number: \_\_\_\_\_

c. Additional immigration information: \_\_\_\_\_

Examples include: Alien or I-94 number, name as it appears on an immigration document, SEVIS ID or expiration date, or other information.

d. Have you lived in the U.S. since 1996?  Yes  No

e. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military?  Yes  No

30. 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

31. Have you been tested for COVID-19? (OPTIONAL)  Yes  No

If yes, enter the date of your earliest COVID-19 test (OPTIONAL) : \_\_\_\_\_

32. Are you currently enrolled in any health coverage?  Yes  No

### Permission to Release Information

**Would you like us to share information about this application with a member of your family or other person of your choice?**

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP
Unit (if applicable)	ID Number (if applicable)		

**NEED HELP WITH YOUR APPLICATION?** Visit [SCDHHS.gov](https://www.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.

## STEP 2

**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 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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). I can review the SCDHHS Notice of Privacy Practices online at [www.scdhhs.gov/NPP](http://www.scdhhs.gov/NPP).

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required on DHHS Form 1282. **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.

## STEP 3

**Submit the completed application.**

Mail your signed application to:

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

OR Fax your application to:

**(888) 820-1204**

OR Email your application to:

**8888201204@fax.scdhhs.gov**

**NEED HELP WITH YOUR APPLICATION?** Visit [SCDHHS.gov](http://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**.

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. 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.

Full Name of Authorized Representative or Organization		<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Remove this person or organization as my authorized representative	
Point of Contact If Authorized Representative Is An Organization	Unit* (if applicable)	ID number (if applicable)	
City	State	ZIP code	
Authorized Representative's phone number	Other phone number		
Authorized Representative's email address			
Authorized Representative's address (Leave blank if you don't have one)			Apartment or suite number

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

**OR**  
**Permission to Release Information**

**Is there anyone that you would like us to share information with about your application?**

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP
Unit (if applicable)	ID Number (if applicable)		

Medicaid applicant/member's signature	Date (mm/dd/yyyy)
---------------------------------------	-------------------

If signing with an "X," please have two people sign below as witnesses.

Witness: \_\_\_\_\_ Witness: \_\_\_\_\_

Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason: \_\_\_\_\_

**Mail your signed form to:** SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax:** (888) 820-1204

**NEED HELP WITH YOUR APPLICATION?** Visit [SCDHHS.gov](http://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**.