TABLE OF APPENDICES

APPENDIX A

NOTICE OF HOSPITALIZATION

Avera
McKennan Hospital
& University Health Center

1325 S. Cliff Ave.
P.O. Box 5045
Sioux Falls, SD 57117-5045
605-322-8000

AveraMcKennan.org

02/04/14

NOTICE OF HOSPITALIZATION

Pursuant to SDCL 28-13, this notice must be mailed to the County Auditor within fifteen (15) days in case of an emergency admission or within seven (7) days in the case of a non-emergency admission. Avera McKennan herewith provides you notice of hospitalization of the following patient:

Patient Name:
Admission Date: 01/31/14
Date of birth: 12/13/1983
Last known address:

If the patient is a minor or under guardianship,
Patient's guardian/address:
Address of patient's guarantor:

Name and address of responsible party, if known: Same as guarantor
Attending Physician: Bradley C MD FACS Thaemert
Location of services: Avera McKennan
Nature and degree of severity of illness: UNRESPONSIVE, FALL, TRAUMA

Anticipated diagnostic or therapeutic services:
Medical Unit: Laboratory Tests (blood, Urine, Tissue, etc.): Radiology (X-Rays, CAT Scans, etc.); Blood and IV Therapy: Inhalation Therapy (Oxygen); Physical Therapy; Drug Therapy (pain medication, antibiotics, etc.)

Estimated reimbursement for services: $100,000.00 (ONE HUNDRED Thousand Dollars)
The hospital has asked the patient or the responsible party, if known, whether the patient has served in any branch of the military, is potentially eligible for Indian Health Services benefits, or is a member of a Native American tribe and the information received in response to the inquiry is as follows: Not eligible for VA or Indian Health benefits or other.
Dated at Sioux Falls, SD 57117-5045 this 02/04/14

Avera McKennan by: Emily Sherman

CERTIFICATE OF SERVICE

I, EMILY J SHERMAN, of Avera McKennan, hereby certify that I mailed the original of this Notice of Hospitalization to the MINNEHAHA County Auditor's office on 02/04/14 in a sealed envelope with first class postage thereon full prepaid, and addressed as follows:

Minnehaha County Human Services, 521 N Main Ave., Ste. 201, Sioux Falls, SD 57104-5965
Dated at Sioux Falls, SD 57117-5045 this 02/04/14

MK00C

Emily Sherman

Sponsored by the Benedictine and Presentation Sisters

APPENDIX B

RELEASE OF MEDICAL INFORMATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

RE: Patient's Name _____

Social Security Number _____

Birth Date _____

Address _____

_____

County of Residence _____

Date of Admission _____

I hereby authorize _____ Hospital to release to my county of residence medical information concerning my care and treatment during this period of hospitalization. I further authorize the county to release such medical information to providers or cooperating state or federal agencies.

This authorization is given only in connection with its use by my county of residence in the administration of its programs under the provisions of SDCL chapters 28-13, 28-13A, and 28-14. I understand that this information will be considered confidential and shared only with individuals, agencies, institutions, or facilities assisting with my financial needs.

I understand that the records concerning this admission may include information regarding drug and/or alcohol abuse, HIV testing, or mental health records. I acknowledge that such information is protected by federal and/or state law and I hereby release the above-named hospital from all legal responsibility or liability that may arise as a result of this action.

A photocopy of this release shall be as valid as the original and shall continue in effect until such time as I notify the county that it is no longer valid.

Dated this _____ day of _____, _____.

_____
Patient's Signature

_____
Signature of parent, guardian, spouse, or authorized representative if patient is either a minor or incapacitated

_____
Relationship to Patient

Revised: 3/98

APPENDIX C

RELEASE OF FINANCIAL INFORMATION

AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

RE: Patient's Name _____

Social Security Number _____

Birth Date _____

Address _____

_____

County of Residence _____

Date of Service _____

I, _____, hereby authorize any individual, agency, institution, or facility to supply financial information to the county of my residence concerning myself and/or my family and to allow inspection and reproduction of financial records in the individual's, agency's, institution's, or facility's possession pertaining to myself and/or my family. I further authorize the county to release such financial information to providers or cooperating state or federal agencies.

This authorization is given only in connection with its use by the county in the administration of its programs under the provisions of SDCL chapters 28-13, 28-13A, and 28-14. I understand that the information will be considered confidential and shared only with individuals, agencies, institutions, or facilities assisting with my financial needs.

A photocopy of this release shall be as valid as the original and shall continue in effect until such time as I notify the county that it is no longer valid.

Dated this _____ day of _____, _____.

_____
Patient's Signature

_____
Spouse's Signature

_____
Spouse's Social Security Number

_____
Signature of parent, guardian, spouse, or authorized representative if patient is either a minor or incapacitated

_____
Relationship to Patient

_____
Parent's Social Security Number

Revised: 3/98

APPENDIX D

COUNTY RELEASE OF INFORMATION FORM

Part 1 AUTHORIZATION FOR RELEASE OF INFORMATION

Birth Date_____

SS# Number_____

_____
Street Address or RFD

_____
City, State & Zip Code

I,_____, being an applicant or client for financial assistance from and in order for them to develop an adequate record and file pertaining to my eligibility and suitability to qualify for services under the laws, rules, regulations and procedures of such agency, hereby authorize any individual or agency of any nature to release and furnish to County any information they have in their files regarding my physical, mental, academic, psychological, drug or alcohol abuse, social and economic condition. This information will be considered confidential information and shared only with institutions and agencies assisting with my financial needs.

This authorization shall be in effect for one year from this date, unless revoked by in writing at any time, except to the extent that action has already been taken to comply with it.

A copy of this release shall be as valid as the original.

Client's Signature _____ Date_____

Spouse's Signature_____ Date_____

Caseworker/Witness_____ Date_____

****

PART II REQUEST FOR INFORMATION

PHONE:
FAX:

Return to _____

APPENDIX E

HOSPITAL APPLICATION FOR COUNTY ASSISTANCE

Avera
McKennan Hospital
& University Health Center

1325 S. Cliff Ave.
P.O. Box 5045
Sioux Falls, SD 57117-5045
605-322-8000

AveraMcKennan.org

06/13/14

APPLICATION FOR POOR RELIEF ASSISTANCE

Pursuant to SDCL 28-13 this application must be submitted to the County Auditor within one (1) year of the discharge of the indigent patient. Avera McKennan makes application for poor relief assistance on behalf of , DOB: 12/13/1983, patient, his/her parents, guardian or other responsible person(s), and provides the following information:

1. Notice of Hospitalization (attached)
2. Dates of Hospitalization: 01/31/14 thru 02/04/14
   Final diagnosis:

   : BRAIN LACER NEC-COMA NOS, ACUTE RESPIRATORY FAILURE, ALCOHOL WITHDRAWAL, ALCOHOL ABUSE-UNSPEC, FALL ON STAIR/STEP NEC

3. Cost of Hospital Services: $47641.43
4. Financial information concerning the patient or responsible party in the possession of the hospital, including the availability of insurance coverage if known: No insurance per patient/guarantor/family.

Dated at Sioux Falls, SD 57117-5045 on 06/13/14

Avera McKennan By: Emily Sherman

CERTIFICATE OF SERVICE

I, EMILY J SHERMAN of Avera McKennan, hereby certify that I mailed the original of this application for poor relief assistance to the MINNEHAHA County Auditor's office on this date, 06/13/14 in a sealed envelope with first class postage thereon fully prepaid, and addressed as follows:
Minnehaha County Human Services, 521 N Main Ave., Ste. 201, Sioux Falls, SD 57104-5965

Dated at Sioux Falls, SD 57117-5045 on 06/13/14

Emily Sherman

MK00

APPENDIX F

ABILITY TO PAY FORM

I. PROCESS OF ESTABLISHING INCOME (RESOURCE) GUIDELINE

	CALCULATE MONTHLY HOUSING ADJUSTMENT		
1.	(County Housing Index) X ($306)		
	DERIVE ANNUALIZED GUIDELINE VIA FORMULA		
2.	(1.75 X (poverty level) + line 1) X 12		

II. PROCESS OF ESTABLISHING ELIGIBILITY

(Step 1:)

	CONSIDERATION OF RESOURCES/ASSETS		
3.	Equity value of primary residence **minus** $30,000 (homestead exemption); **Plus** entire equity value of other real property		
4.	Equity value of recreational and leisure equipment		
5.	Equity value of motor vehicles in excess of $5,000		
6.	Cash in excess of one-half month's income		
7.	Personal assets, savings, CDs, stocks, securities, notes due, cash value of life insurance, judgments receivable, and monetary gifts		
8.	Equity value of business property, including real estate, equipment, and inventory		
9.	Household goods and personal property beyond that which can reasonably be considered to be essential for everyday living and self support		
10.	One time capital gains		
11.	Total lines 3 through 10 (equals estimate of net assets/resources)		
12.	Subtract $5,000		
13.	Balance equals adjusted resources/assets		

(Step 2:)

	DERIVE TOTAL MONTHLY INCOME		
14.	Gross salary, wages, commissions, and bonuses		
15.	Self-employment income		
16.	Pension, social security, and VA disability insurance payments		
17.	Annuities and/or trust income		
18.	Interest, dividends, rents, royalties, and investment gains		
19.	Unemployment compensation and/or strike benefits		
20.	Workers compensation benefits and/or settlements		
21.	Alimony and child support		
22.	School grants and stipends (excluding grants for books & tuition)		
23.	Total lines 14 through 22 (equals unadjusted gross monthly income)		
24.	Add adjusted resources/assets from line 13		
25.	Compute gross annual income (12 X line 23 .00 + line 24 .00)		

(Compare line 25 to line 2. If line 25 is less, individual is income eligible. If line 25 is greater, individual is not income eligible. Regardless of outcome, continue to next page)

III. PROCESS OF ESTABLISHING ABILITY TO PAY (CO-PAYMENT)

(Step 1:)

	CALCULATE DEDUCTIONS FROM MONTHLY INCOME		
26.	Income taxes and contributions to social security & medicare, etc.		
27.	Contributions to standard retirement programs		
28.	Total of lines 26 and 27 (equals total deductions)		

	CALCULATE MONTHLY EXPENSES		
29.	Actual rent paid or scheduled principle and interest payments for a personal residence **plus** property taxes and homeowners insurance costs		
30.	All utilities		
31.	Child care expenses related to work schedules		
32.	Grocery expenses (maximum allowance under the Thrifty Food Plan **plus** household supplies and toiletries)		
33.	Basic auto expenses, gasoline, and upkeep		
34.	Employee paid health _____.00, life _____.00, auto ins. _____.00		
35.	Monthly health or medical installment payments		
36.	Customary monthly expenses for medicine and medical care		
37.	Court-ordered child support and alimony payments		
38.	Automobile installment payments pertaining to <u>one</u> vehicle		
39.	Other expenses (including clothing and installment debt for necessary household items)		
40.	Total of lines 29 through 39 (equals total basic monthly expenses)		

	CALCULATE MONTHLY DISCRETIONARY INCOME & DEBT LOAD		
41.	Line 23 _____.00 **minus** line 28 _____.00 **minus** line 40 _____.00		
42.	Line 41 _____.00 X 50% (equals one-half of discretionary income)		
43.	Line 42 _____.00 X $44.96 (equals the amount of debt which can be amortized over 60 months at 12 % annual interest per dollar of payment)		

(Step 2:)

	CALCULATE HOUSEHOLD'S ABILITY TO PAY		
44.	Enter the amount of adjusted assets/resources from line 13		
45.	Enter the household's debt load from line 43		
46.	Total of lines 44 and 45 (equals total ability to pay and constitutes the household's share of the hospital bill)		

(Step 3:)

	CALCULATE COUNTY'S SHARE		
47.	Enter the hospital charges computed according to SDCL 28-13-29		
48.	Subtract line 46, the household's ability to pay		
49.	Balance equals the county's obligation		

APPENDIX G

EMERGENCY MEDICATION ASSISTANCE APPLICATION

APPLICATION
FOR
EMERGENCY MEDICATION ASSISTANCE

NAME OF COUNTY: _____

NAME OF APPLICANT: _____

ADDRESS: _____

SSN: _____ DOB: _____

DO YOU HAVE SSI/SSD PENDING: YES: _____ NO: _____

CO-APPLICANT: _____

SSN: _____ DOB: _____

NAME OF MEDICATION: _____

STRENGTH: _____

DOSAGE: _____

NUMBER OF DOSES _____

NUMBER OF REFILLS: _____

NAME OF PHARMACY: _____

I understand that, in accordance with SDCL 28-14-7, a lien will be filed against me and any personal property or real estate that I now own or have any legal interest in, or may own in the future, for any assistance provided on my behalf by the county. I further understand that state law requires me to repay the county for the assistance provided. Failure to repay the county may result in a collection action against me.

I also understand that, should I not follow through with my application scheduled at: _____ on _____, I am not eligible for any further assistance until that application has been completed.

APPLICANT SIGNATURE _____ DATE _____

CASEWORKER SIGNATURE _____ DATE _____

CCPR-AEMA (2002)

APPENDIX H

MEDICAL FINANCIAL FORM

MEDICAL FINANCIAL FORM

NAME: _____ SS #: _____ CASE #: _____

SPOUSE: _____ # OF CHILDREN IN THE HOME UNDER 18: _____

Please provide documents for items listed on this page for verification of assets/ income on a monthly basis. A check box has been provided to mark that you have obtained the document and a line to write in the dollar amount.

ASSETS (self and spouse)

☐ _____ Value of: _____primary residence _____other property

☐ _____ Value of: _____vehicles _____recreational and leisure equipment (for values go to www.nada.com or www.kbb.com)

☐ _____ Cash available (checking/savings statements from the last 90 days)

☐ _____ Personal assets (CD's, stocks, securities, notes due, cash value of life insurance, judgments receivable and monetary gifts)

☐ _____ Value of business property, including real estate, equipment and inventory

☐ _____ ESTIMATED VALUE of household goods and personal property not considered essential for everyday living (TV's, DVD players, stereo systems, jewelry, guns, etc)

☐ _____ One-time gains (lump sum settlements, inheritances, winnings, etc)

☐ _____ Other

INCOME (self and spouse)

☐ _____ Pay stubs of wages, commissions and bonuses for the last 90 days

☐ _____ Self employment income (profit and loss statement for the last 90 days)

☐ _____ Pension, social security and VA disability insurance payments

☐ _____ State assistance programs: _____ SNAP _____Child Care assistance _____Unemployment compensation _____TANF

☐ _____ Annuities and/or trust income

☐ _____ Interest, dividends, rents, royalties and investment gains

☐ _____ Workers compensation, settlements or strike benefits

☐ _____ Alimony and child support

☐ _____ School grants and stipends (excluding grants for books and tuition)

☐ _____ Other

(OVER)

MEDICAL FINANCIAL FORM

Please provide documents for items listed on this page for verification of taxes/expenses on a monthly basis in addition to personal information. A check box has been provided to mark that you have obtained the document and a line to write in the dollar amount. ***If you make a payment to another person rather than paying directly to a landlord or business, you will need a written, signed and dated statement from that person verifying the amount you are making for payments on those bills.

EXPENSES (self and spouse)

☐ _____ Actual rent paid or scheduled principle and interest payments for a personal residence, plus property taxes and homeowners/renters insurance

☐ _____ Utilities: _____electric _____gas _____water _____garbage _____phone

☐ _____ Child care cost expenses related to work/school schedules

☐ _____ ESTIMATED gasoline expenses: _____car 1 _____car 2

☐ _____ Health insurance premium

☐ _____ Life insurance premium

☐ _____ Auto insurance premium: _____car 1 _____car 2

☐ _____ Health or medical installment payments

☐ _____ Medications and medical care

☐ _____ Child support and/or alimony payment

☐ _____ Automobile installment payments: _____car 1 _____car 2

☐ _____ Other expenses (student loans, storage, fines, restitution, etc)

PERSONAL

☐ Social Security Card (self and spouse)

☐ Picture ID (self and spouse)

☐ Copy of hospital billing statement(s) and bills from other medical providers during your hospitalization(s)

☐ Income tax return for year of _____

_____ _____

SIGNATURE **DATE**

APPENDIX I

NEEDYMEDS.COM

(../index.htm)

HELPLINE (800) 503-6897 (../inclusions/helpline.htm)
CONTACT US (../inclusions/contact_us.htm)
EN ESPANOL (http://www.es.needymeds.org/index_es.htm

Find help with the cost of medicine

DONATE NOW (../INCLUSIONS/DONATE_NEW.HTM)

- Menu
- Home (/index.htm)
- Patient Savings
- Advocates
- Getting Started
- Services
- About Us
- News
- Blog (http://blog.needymeds.org/)

NeedyMeds Supports the Access Our Medicine Initiative

Add Your Voice!

NeedyMeds is proud to support the Access Our Medicine Declaration (http://bit.ly/1hh8ZCx) in their quest for 100,000 voices for affordable medicine. Read more (../inclusions/aom_info.htm) about NeedyMeds' partnership with AOM.

Please take a second to add your voice today:

Full Name

Your Email Address:

City:

☑ **Yes, I'd like to receive updates on the Access Our Medicine Initiative**

Submit

Over $84,606,490.09 Saved
With NeedyMeds Drug Card

ERT

(http://www.needymeds.org/gap.htm)

Generic Assistance Program (GAP)

GAP offers nearly 20 generic medications (http://www.needymeds.org/gap.htm) at no cost to people who meet the program eligibility guidelines.

(http://www.needymeds.org/gap.htm)

(../inclusio

Be on the

Some web
programs.
assistance

ering medication
, set refill and dose

1 2 3 4 5 6 7

Partners

ZipTrials.us

(http://www.ziptrials.us)

1 2 3 4 5

The information on this website is intended for general knowledge and not as a replacement for medical advice from your physician. We do not prescribe medicine nor make medication suggestions. Links to other sites do not constitute endorsements of the information on those sites.

Start typing drug name

Drug Search

APPENDIX J

GENERAL APPLICATION FOR COUNTY ASSISTANCE

Date	Last Name	IC New	Case #

For office use only

Application for County Assistance

Primary language	Do you need an Interpreter? Y N

Please check the type of assistance you are requesting:

☐Rent ☐Deposit ☐Utility ☐Medication ☐Food ☐Bus Passes ☐ID ☐Dental ☐Medical ☐COBRA ☐Other

Please list ALL household members, starting with you:

FULL NAME: first, middle, last include maiden name	Relationship to Applicant	Sex	Race	Education	Current School	Birth Date & Birth Place	SS #
	Self		Tribal affiliation Y N	Last grade completed ____ Degree Y N			
			Tribal affiliation Y N	Last grade completed ____ Degree Y N			
				Last grade completed ____			
				Last grade completed ____			
				Last grade completed ____			
				Last grade completed ____			

Current Street Address	Apt #	City	County	Zip

Date moved in	Rent $ Subsidized Y N	Deposit $	Lot Rent $	Mortgage $ Loan #	#Bedrooms	Home Phone Cell Message

Landlord/Mortgagor	Landlord Address	Landlord Phone

Which utilities do you pay? ☐Gas ☐Propane ☐Electric ☐Water/Sewer ☐Garbage ☐Phone ☐Cell phone ☐Cable ☐Internet

MARITAL STATUS ☐Single (never been married) ☐Married ☐Separated ☐Divorced ☐Widow(er)

Married To	Date	City	State
Divorced From	Date		
Separated From	Date		

CITIZENSHIP STATUS ☐US Citizen ☐Eligible Non-Citizen ☐Ineligible Non-Citizen

If not a US Citizen, Alien # & Entry Date (into the United States) is required. Alien # _____ Entry Date: ____/____/____

HOUSING HISTORY & BARRIERS

Previous Address	Rent $	Date Left	Reason for Leaving

Are you currently homeless? Includes living with friends/relatives.	Y N	Date you became homeless:
Have you ever been evicted/asked to leave a residence you rented or owned?	Y N	Date: Reason:
Have you ever been evicted/asked to leave any Housing Programs including Heartland House, St. Francis House, Dakota/Lakota House, Section 8 or HUD?	Y N	Date:
Are you or any member of your household a registered sex offender in any state?	Y N	State:
Have you/anyone in the home been convicted of a violent or drug related crime or a felony?	Y N	Date of conviction:
Are you currently on the Sioux Falls Housing waiting list?	Y N	Date applied:

FAMILY

Note: Your nearest relative may live in another state.

Parents Names (if living)	Address	Employer	Able to provide assistance? Please explain.
Spouse's Parents (if living)			
Nearest Relative's Name			
Spouse's Nearest Relative			

CHILD SUPPORT

Child Support Orders	Child's Name	Parent's Names	Address	Employer
Current child support order? Y N Amount of the order $				
Current child support order? Y N Amount of the order $				

MILITARY SERVICE (all branches including National Guard & Reserves) NO VETERANS IN THE HOME ☐

Service Member's Name	Branch	Dates	Discharge Type

Applied for VA Medical Services? Y N	Outcome?	Applied for VA Housing Programs? Y N	Outcome?

HEALTH & INSURANCE

Name	Health Diagnosis	Medication(s)	Medication out of pocket cost per mo	Pharmacy	Medical Insurance Provider	Insurance out of pocket cost per mo
Self					Medicaid Y N Other:	
					Medicaid Y N Other:	
					Medicaid Y N Other:	

If no insurance but you take medications, have you applied for any prescription assistance programs? Y N

EMPLOYMENT: List current and previous employment information for everyone in the home

Name	Employer	Start Date	End Date	Job Title	Wages	Hours per week	Why Left
Self	Current						
	Previous						
	Previous						
	Current						
	Previous						
	Previous						

VEHICLE(S)

Year	Make/Model	Date of Purchase	Payment Per Month	Balance Owed $	Value $	Owner's Name

INCOME/ASSETS (not previously listed)

Income Type	Amount	Assets	Value/ Amount
SSDI		HOME	
SSI		BUSINESS	
SS		LAND	
SNAPS (FOOD STAMPS)		VEHICLE(S)	
TANF		TAX REFUND	
CHILD SUPPORT		SAVINGS ACCOUNT	
RENT or UTILITY assistance within the last year	Y N $	Bank:	
CHILDCARE ASSISTANCE	Y N	CHECKING ACCOUNT	
ENERGY ASSISTANCE (LIEAP)	Y N $	Bank:	
UNEMPLOYMENT		STOCKS/BONDS	
WORKER'S COMP.		CDs/IRAs	
VETERAN'S BENEFITS		INHERITANCE/TRUSTS	
RETIREMENT		401 K PLAN	
RENTAL/LAND INCOME		LAND OWNED	
WIC	Y N	STUDENT LOANS	
UTILITY CHECK		LIFE/BURIAL POLICY	
ALIMONY		BELONGINGS SOLD	
OTHER		OTHER	

EXPENSES (not previously listed)

Monthly Expenses	Amount you pay per month
CAR INSURANCE	
RENTER'S INSURANCE	
LIFE INSURANCE	
CHILDCARE	
PAYDAY LOANS	
TITLE LOANS	
MEDICAL BILLS	
CHILD SUPPORT	
WAGE GARNISHMENTS	
CREDIT CARDS	
LEGAL (fines, restitution etc)	
STUDENT LOANS	
PAWN TICKETS	
RENT-TO-OWN ITEMS	
GASOLINE	
FOOD (above what food stamps covers)	
HYGIENE/CLEANING ITEMS	
OTHER	
OTHER	

I DECLARE AND AFFIRM, UNDER THE PENALTIES OF PERJURY AND DENIAL OF BENEFITS, THAT THE ABOVE INFORMATION GIVEN IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND CORRECT.

SIGNATURE_____ DATE_____

APPENDIX K

APPLICATION FOR COUNTY MEDICAL ASSISTANCE

APPLICATION
FOR
MEDICAL ASSISTANCE

County of Residence: _____

Applicant's Full Name: _____

AKA (Also Known As): _____

Maiden Name (if applicable): _____

Address: _____

Telephone Number: Home: _____ Work: _____

SSN: _____ DOB: _____

Are there any other Social Security numbers that you have used in the past: Yes ___ No ___
If yes, please list those numbers: _____

Marital Status (circle one): Married Separated Divorced Single Widowed
If formerly married, list name of former spouse(s), date of marriage, divorce, death or separation: _____

PLEASE COMPLETE SPOUSE INFORMATION IF NOT LEGALLY DIVORCED

Spouse's Full Name: _____

AKA (Also Known As): _____

Maiden Name (if applicable): _____

Address: _____

Telephone Number: Home: _____ Work: _____

SSN: _____ DOB: _____

Are there other Social Security numbers that your spouse has used in the past: Yes ___ No ___
If yes, please list those numbers: _____

SIGNIFICANT OTHER TO WHOM NOT LEGALLY MARRIED

Full Name: _____

AKA (Also Known As): _____

SSN: _____ DOB: _____

PLEASE LIST ALL OTHER HOUSEHOLD MEMBERS FOR WHOM YOU ARE RESPONSIBLE

Full Name: _____

SSN: _____ DOB: _____

Full Name: _____

SSN: _____ DOB: _____

Full Name: _____

SSN: _____ DOB: _____

Full Name: _____

SSN: _____ DOB: _____

Does anyone besides yourself claim you as a dependent on their income tax: _____

HISTORY OF RESIDENCE

How long have you lived in this county: _____

Previous address: _____ County: _____

Did you/spouse move to this county for purposes of medical care: Yes _____ No _____
If yes, please explain: _____

MEDICAL INFORMATION

Was this illness an emergency: Yes ___ No ___ Date of emergency: _____

If yes, please explain: _____

If no, please list date of scheduled service: _____

Has your doctor authorized you to return to work: Yes _____ No _____

If no, when is your anticipated date of return: _____

Are you a Native American: Yes ___ No ___ Are you a Veteran: Yes ___ No ___

If you are a Native American, are you an enrolled tribal member: Yes _____ No _____

If yes, what tribe: _____

If you are a Veteran, are you enrolled with the V.A. Hospital: Yes _____ No _____

Have you tried or have you been making reasonable payments to the hospital: Yes ___ No ___

If yes, what was the amount due on the hospital bill: _____

What is the amount of your monthly payment: _____

How much have you paid on this bill: _____

LEGAL CLAIM INFORMATION

Are you or your spouse currently involved in a law suit: Yes _____ No _____

If yes, briefly explain: _____

Please provide the name, address, and telephone number of the attorney handling your lawsuit:

Have you or your spouse ever been involved in a law suit: Yes _____ No _____

If yes, briefly explain: _____

Please provide the name, address, and telephone number of the attorney handling this lawsuit:

Settlement date, amount and terms: _____

Do you have a pending workers' compensation claim: Yes _____ No _____

If yes, specify who the claim is against and the date of the incident: _____

Please provide the name, address, and telephone number of the attorney handling this claim:

_____

_____

Have you ever filed a workers' compensation claim: Yes _____ No _____

If yes, specify who the claim was against and the amounts and terms of the settlement:

_____

_____

EMPLOYMENT INFORMATION

Applicant's current employer: _____

Address: _____ Telephone: _____

Hourly pay rate: _____ Hours per week: _____

Date of employment: _____

Previous employer: _____

Address: _____ Telephone: _____

Hourly pay rate: _____ Hours per week: _____

Start and end date: _____

Is/was health insurance provided/offered: Yes _____ No _____

Date eligible: _____ Amount of premium: _____

If not employed, other sources of income and amounts: _____

_____

_____

EMPLOYMENT INFORMATION FOR SPOUSE/SIGNIFICANT OTHER

Current employer: _____

Address: _____ Telephone: _____

Hourly pay rate: _____ Hours per week: _____

Date of employment: _____

Previous employer: _____

Address: _____ Telephone: _____

Hourly pay rate: _____ Hours per week: _____

Start and end date: _____

Is/was health insurance provided/offered: Yes _____ No _____

Date eligible: _____ Amount of premium: _____

If not employed, other sources of income and amounts: _____

FINANCIAL ASSETS AND RESOURCE INFORMATION

Have you or your spouse been the beneficiary of an inheritance: Yes _____ No _____

If yes, please specify what was inherited, the value of the inheritance, and the date of the inheritance: _____

Do you or your spouse anticipate receiving an inheritance: Yes _____ No _____

If yes, estimated amount: _____

Do you or your spouse anticipate receiving income from outstanding loans you have given:

Yes _____ No _____ If yes, please specify to whom the loan was made, the amount of the loan, the payment amount on the loan, and the repayment schedule: _____

Have you or your spouse received or anticipate receiving an IRS tax refund: Yes ___ No ___

If yes, please specify the amount of the refund and the date received or the anticipated date of receipt: _____

Have you applied for Social Security Disability benefits: Yes _____ No _____

If yes, please specify the date of application and the current status of the application, including pending appeals and hearings: _____

Have you ever received a lump sum from Social Security for retroactive pay: Yes No

If yes, please specify how much was received and date received: _____

Are you currently receiving any loans, grants, or stipends for living expenses (not tuition or books) while attending a post-secondary school: Yes _____ No _____

If yes, please specify the amount received and the time frame it covers: _____

IF YOU OR YOUR SPOUSE HAVE ANY OF THE FOLLOWING ASSETS, PLEASE LIST INCLUDING THE AMOUNTS AND THE ACCOUNT NUMBERS

TYPE	AMOUNT	ACCOUNT NUMBER
One Time Capital Gains:		
Mutual Funds:		
IRA's		
Retirement Plan:		
Annuities:		
Investments:		
Stocks:		
CD's		
Money Markets:		
Disability Income:		
Savings:		
Checking Accounts:		
Bonds:		
Any Other Investments Or Money Holding Institutions:		

Are you or your spouse listed on a joint account with another individual: Yes ____ No ____

Are you listed as a dependent on anyone else's Income Tax return: Yes ____ No ____

If yes, please explain: _____

If yes, please specify the name of the other individual, a description of the account, the holder of the account, and the account number: _____

INCOME/ASSISTANCE INFORMATION

TYPE	APPLICANT	SPOUSE/OTHER(S)	
	Amount	*Name*	*Amount*
Social Security:			
SSI/SSD:			
VA Benefits:			
Nat'l Guard/Reserve:			
BIA/GA Tribal Funds:			
Lease Payments:			
TANF:			
Foster Care:			
Salary, Wages, Commissions, Bonuses:			
Disability Insurance Payment:			
Self-employment:			
Unemployment Benefits:			
Workers' Comp.:			
Vacation/Sick Leave:			
Retirement:			
Strike Benefits:			
Alimony:			
Child Support:			
Insurance Settlement:			
Insurance Face Value:			
Scholarship(s) After Tuition/Books:			
Loans, Grants After Tuition/Books:			
Interest, Dividends, Rents, Royalties, Investment Gains:			
IRS Refund:			

RESOURCES

TYPE	AMOUNT
WIC:	
Food Stamps:	
LIEAP:	
Subsidized Housing:	
Child Care Assistance:	
Utility Allowance:	

MONTHLY EXPENSES

TYPE	AMOUNT
Court-ordered Child Support:	
Rent/Mortgage:	
Day Care:	
Utilities (Gas/Lights/ Water/Telephone):	
Groceries:	
Student Loans:	
Basic Auto Expenses, Gas & Upkeep:	
Monthly Health or Medical Installment Payments:	
Customary Monthly Expenses for Medicine & Medical Care:	
Court-ordered Alimony:	
Automobile Installment Payments Pertaining to One Vehicle:	
Other Expenses (Clothing & Installment Debt For Necessary Household Items:	

INSURANCE

TYPE	AMOUNT
Medical/Dental:	
Car:	
Life:	
House:	
Renters:	
Lot Rent:	
Other (Explain):	

PROPERTY VALUE OF HOME AND OTHER REAL PROPERTY

Property	Current Fair Market Value		Encumbrances		Equity Value
House/Real Estate:	_____	-	_____	=	_____
Vehicles:	_____	-	_____	=	_____
Recreational Vehicles:	_____	-	_____	=	_____
Other (please list):	_____	-	_____	=	_____
	_____	-	_____	=	_____
	_____	-	_____	=	_____

BUSINESS PROPERTY

Do you or your spouse currently own a business: Yes _____ No _____

If yes, please indicate the name of the business, its location, and the dates of ownership:

_____

_____

Have you or your spouse owned a business in the past: Yes _____ No _____

If yes, please indicate the name of the business, its location and the dates of ownership:

_____

Equity value of equipment, property and inventory: _____

_____

Are you or your spouse currently a partner/silent partner in a business: Yes _____ No _____

If yes, please indicate the name of the business and its location: _____

_____

Have you or your spouse sold or transferred any property within the last 36 months or in the 36 months prior to the onset of this illness: Yes _____ No _____

If yes, please explain: _____

_____

Are you or your spouse involved in a contract for deed or lease situation either as a seller or a buyer: Yes _____ No _____ If yes, please explain: _____

INSURANCE INFORMATION

Do you have a life insurance policy: Yes _____ No _____

If yes, is it whole life or term life: _____

Limits of policy: _____ Cash value of policy: _____

Please specify who the beneficiaries are: _____

Have you or your spouse applied or been turned down for health insurance in the past 12 months: Yes No If yes, why: _____

Have you or your spouse ever been eligible for health insurance under COBRA provisions: Yes _____ No _____ If yes, what was the premium amount: _____

Have you ever refused health insurance coverage available under COBRA provisions: Yes _____ No _____ If yes, when: _____

Is health insurance offered through your or your spouse's employer: Yes _____ No _____

If yes, please state monthly premium amount: _____

Were you a college student during the time of this illness or emergency: Yes _____ No _____

If yes, did you purchase the insurance plan offered through the school: Yes _____ No _____

CITIZEN INFORMATION

Are you a citizen of the United States: Yes _____ No _____

If not, what is your citizen status:

ACKNOWLEDGEMENT

I, the undersigned applicant or representative, declare and affirm under the penalties of perjury that this application has been examined by me and, to the best of my knowledge and belief, is in all things true and correct. I further acknowledge that I may be prosecuted under the provisions of SDCL 28-13-16.2 if I sign this application knowing the information contained herein is false in whole or in part.

I understand that, under the provisions of SDCL 28-14, a lien will be filed against me and any personal property or real estate that I now own or have a legal interest in or property that I may own in the future for assistance given me by the county. I further understand that I am required by law to repay the county for assistance given. Should there be no action made to repay this lien, it will be subject to collection.

Applicant: _____ Date: _____

Spouse: _____ Date: _____

APPENDIX L

REQUEST FOR FINANCIAL INFORMATION

REQUEST FOR FINANCIAL INFORMATION

To Whom It May Concern:

The county is in the process of determining financial eligibility for county assistance for the below-listed individuals. Please complete the following information if any of the individuals have accounts, certificates of deposit, or trusts at your financial institution that are owned solely or jointly by the individual listed.

Individual	Social Security Number

Type of Account	Current Balance	Interest Bearing (yes/no)	Percent of Interest	How Often Interest Paid

If there have been transactions within the last 36 months that resulted in the redemption or transfer of a financial resource, please specify what was transferred, the amount transferred, and the date of the transfer.

An Authorization for the Release of Information is attached. Thank you for your assistance.

CASEWORKER: _____

COUNTY: _____

ADDRESS: _____

Information Provided By: _____ Date: _____

CCPR-RFFI (2002)

APPENDIX M

NOTIFICATION OF COUNTY ASSISTANCE

NOTIFICATION OF COUNTY ASSISTANCE

CLIENT NAME: _____

DATE OF ADMISSION: _____

ACCOUNT NUMBER: _____

Total Hospital Charges Computed according to SDCL 28-13-29: $ _____

Household Share: $ _____

County Share: $ _____

COMMENTS: _____

CASEWORKER: _____

COUNTY: _____

ADDRESS: _____

FAX: _____

CCPR-NOCA (2002)

APPENDIX N

NOTICE OF INELIGIBILITY

NOTICE OF INELIGIBILITY

Client's Name(s): _____

The above named individual(s) have been found to be ineligible for assistance due to the following reason(s):

_____	28-13-1.3(1)	Third party resources available.
_____	28-13-1.3(2)	Ability to make reasonable payments.
_____	28-13-1.3(3)	Voluntarily reduced or eliminated assets.
_____	28-13-1.3(4)	Indigent by design.
_____	28-13-1.3(5)	Eligible for services through Veterans' Administration or Indian Health Services.
_____	28-13-27(6)(a)	Able to work but has chosen not to work.
_____	28-13-27(6)(b)	Student at a post-secondary institution who chose not to take the insurance offered through the institution.
_____	28-13-27(6)(c)	Failed to purchase health insurance through employer.
_____	28-13-27(6)(d)	Failed to purchase health insurance when individual was insurable and insurance was affordable.
_____	28-13-27(6)(e)	Transferred resources within the past 36 months.
_____	28-13-27.1	Services must be medically necessary.
_____	28-13-32.9	Has the ability to pay.
_____	28-13-32.10	Indigent by design and no other criteria may be used.
_____	28-13-33	Prior approval required for non-emergency admissions.
_____	28-13-33.2	Hospital must exhaust all avenues of payment including accepting reasonable monthly payments from the individual.
_____	28-13-34.1	Notice of emergency hospitalization must be sent to the county within 15 days.
_____	Other	Explain: _____

If you have any additional information or your circumstances have changed since your application, please bring this to our attention and we will review your case. You have the right to appeal to the County Commissioners within 10 days if you disagree with the decision of this office.

Caseworker: _____ Date of Notice: _____

CCPR-NOI (2002) (APP L)

APPENDIX O

UB-O4

1	2	3a PAT. CNTL # / b. MED. REC. #	4 TYPE OF BILL
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME a / b	9 PATIENT ADDRESS a / b / c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							A
B						57 OTHER PRV ID	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX									68

69 ADMIT DX		70 PATIENT REASON DX				71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

INPATIENT

1 Any Hospital 123 Any Street Philadelphia PA 19103	2 Any Hospital 456 Any Street Philadelphia PA 19103	3a PAT. CNTL # 1234 b. MED REC. # 98765	4 TYPE OF BILL 0111
		5 FED. TAX NO. 221234567	6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06
			7 RESERVED

8 PATIENT NAME: a Patient ID if different from Sub; b Doe, John

9 PATIENT ADDRESS: a 1234 Main Street; b Philadelphia; c PA; d 19111 — Country code if other than USA

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
03 20 1971	M	11 03 06	08	3	3	12	01	Condition Codes Required Identifying Events											PA	RESERVED

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing														FUTURE USE

38 John Doe
1234 Main Street
Philadelphia, PA 19111

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a A1	952.00				
b Value Codes and amounts required when necessary to process claim					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0129	Semi-Private	200.00		2	400.00	0.00	Future Use
2	0250	Pharmacy			1	50.00	0.00	
3	0360	OR Services				100.00	0.00	
23	PAGE 1 OF 1		CREATION DATE		TOTALS	550.00	0.00	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	Independence Blue Cross	Report HIPAA National Health Plan Identifier when mandatory	Y	Y	Required when indicated payer has paid amount to Provider	Amount estimated to be due	2222222222	
B	Secondary Payer						57 OTHER PRV ID: 1234567890 Secondary	
C	Tertiary Payer						Tertiary	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, John	18	ABC1234567800	Watch Repair, Inc.	1234
B	Secondary				
C	Tertiary				

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	02468	491234	Watch Repair, Inc.
B	Secondary		
C	Tertiary		

66 DX: 3910 — Use A through Q to report "Other Diagnosis" if applicable; 67 Reserved

69 ADMIT DX: 4280; 70 PATIENT REASON DX: May be used to report reason for visit; 71 PPS CODE: DRG; 72 ECI: May be used to report external cause of injury; 73 Reserved

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75 Reserved
3749	11 03 06					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING: NPI 2222222222; QUAL 1G 1234569822; LAST Smith; FIRST David

77 OPERATING: NPI; QUAL; LAST; FIRST

78 OTHER: NPI; QUAL; LAST; FIRST

79 OTHER: NPI; QUAL; LAST; FIRST

80 REMARKS: May be used to report additional information.

81CC a	83	282N00000X
b		Secondary
c		Tertiary
d		

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

3 12.09

Red = Required
Black = Situational/Required, if applicable/Reserved

Independence Blue Cross
www.ibx.com

OUTPATIENT

1 Any Hospital 123 Any Street Philadelphia PA 19103	2 Any Hospital 456 Any Street<| Philadelphia PA 19103	3a PAT. CNTL # 1234 b MED. REC. # 98765	4 TYPE OF BILL 0131
		5 FED. TAX NO. 221234567	6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06	7 RESERVED

8 PATIENT NAME a Patient ID if different from Sub b Doe, John	9 PATIENT ADDRESS a 1234 Main Street b Philadelphia	c PA	d 19111 Country code if other than USA

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
03 20 1971	M	11 03 06	08	3	3	12	01	Condition Codes Required Identifying Events											PA	RESERVED

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing														FUTURE USE

38
John Doe
1234 Main Street
Philadelphia, PA 19111

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A1	952:00				
b	Value Codes and amounts required when necessary to process claim					
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0310	Laboratory N400093723106	88173	11 03 06	1	100:00	0:00	Future Use
2	0402	Ultrasoud	76942	11 04 06	1	100:00	0:00	
3	0360	OR Services	3749	11 04 06	1	100:00	0:00	
23	PAGE 1 OF 1		CREATION DATE		TOTALS	300:00	0:00	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. B/F/O	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	Independence Blue Cross	Report HIPAA National Health Plan Identifier when mandatory	Y	Y	Required when indicated payer has paid amount to Provider	Amount estimated to be due	2222222222	
B	Secondary Payer						57 OTHER PRV ID 1234567890	
C	Tertiary Payer						Secondary Tertiary	

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, John	18	ABC1234567800	Watch Repair, Inc.	1234
B	Secondary				
C	Tertiary				

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	02468	491234	Watch Repair, Inc.
B	Secondary		
C	Tertiary		

66 DX: 3910 — Use A through Q to report "Other Diagnosis" if applicable — 68 Reserved

67:

69 ADMIT DX: 4280 — 70 PATIENT REASON DX: May be used to report reason for visit — 71 PPS CODE: DRG — 72 ECI: May be used to report external cause of injury — 73 Reserved

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
3749	11 04 06					Reserved
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 2222222222	QUAL 16	1234569822
LAST Smith		FIRST David	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS
May be used to report additional information.

	81CC	
a	03	282N00000X
b		Secondary
c		Tertiary
d		

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Red = Required
Black = Situational/Required, if applicable/Reserved

APPENDIX P

1500 CLAIM FORM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoB#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For Govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

APPENDIX Q

COUNTY COST-TO-RATIO FORM

Hospital Request for Payment County of _____

This form is recommended by SDHA and SDACC and is not an official form of the Department of Health.
Date: 11/24/2014
Claim of: Avera McKennan Hospital
Address: 800 E. 21st St. Sioux Falls, SD 57101
Account : #
Patient Name:
Date of Birth:
Address:
Guarantor:
Address:
Inpatient: ☐ /Outpatient: ☒
Final Diagnosis: Contusion Face/Scalp/Neck
Attending Physician:
Date admitted:

An itemized bill for services covered by this request for payment is attached. Following is the computation by which the hospital reimbursement is determined. The ratios in column 2 are taken from the "Hospital Statement of Cost" for the hosptial's most recent fiscal year which has been filed with and is available from the South Dakota Department of Health. Where the ratio of cost to charge is greater than 1.0, payment is limited to the billed charge. Where the ratio is less than 1.0 payment is limited to the appropriate percent ratio of the charge.

1 stmt of Hosp srvcs. Chgs rendered	X 2 ratio of cost to charge	3 amount due from county per SDCL28-13	stmt covers total days 11/04/2014
A. INPT ROUTINE			STATUS OF DISCHARGE
SVC COST CTRS			0. ☐ DIED
DAYS			1. ☐ TO OTHER HOSP.
RATE			2. ☐ EXTENDED CARE FAC
			3. ☐ HOME
B. SPECIAL CARE			ADDRESS IF 1 OR 2:
INTENSIVE UNIT			
CORONARY UNIT			
DAYS			
RATE			OTHER COVERAGE: ☐ Y ☐ N
			IF Y, NAME OF CO OR AG
C. NURSERY CARE			
DAYS			
RATE			
D. ANCILLARY SVC COST			
RATE 5404.56	22.97%	1241.43	COUNTY NOTIFIED
			DATE
E. TOTAL: 5404.56	Disc.-4163.13	1241.43	BY WHOM
F. LESS PMT/CREDITS			
G. BAL DUE FR COUNTY		1241.43	

Verification of Claim

Patti Smith, being first duly sworn on oath, deposes and states that the information in this Request for Payment has been examined and that such information concerning this account is just and true, That the statement of services rendered accurately reflects the services rendered to the patient and the value As charged, to the best of affiants knowledge and belief.

Subscribed to and sworn to me on this date, _____

Notary Public, South Dakota _____ My Commission Expires _____

For county use only:

I hereby certify that the above services have been reviewed and approved by me.

_____

Official approving services

Deb McFarlane
NOTARY PUBLIC
SOUTH DAKOTA

15

APPENDIX R

FORMS FOR MEDICATION ASSISTANCE

INFORMATION NEEDED TO COMPLETE
APPLICATION FOR ASSISTANCE FOR MEDICATIONS

APPOINTMENT FOR: _____

COUNTY: _____

In order for the county to be able to process your application as quickly as possible, it is essential for you to review this entire packet and fill out the information as complete as possible for your appointment on:

DAY: _____ DATE: _____ TIME: _____

If you have any questions, please call _____. It is important that you keep the above-referenced appointment. If you are unable to keep the appointment, please call and cancel. When you return for your appointment, you will need to provide the following documentation, if applicable to your situation:

1. Letter from your mortgage company stating loan balance and monthly payment, which payment may include the principal, interest, taxes, and insurance (PITI).
2. Tax assessment of property.
3. Title/bill of sale and loan payoff on all recreational vehicles, cars, boats, motorcycles or any other motor vehicles and the monthly payment.
4. Cash on hand and in bank accounts, CDs, trusts, annuities, investments, and capitol gains.
5. Equity value of business real estate, equipment, and inventory.
6. A copy of last year's completed tax form.
7. Record of gross income for the past 60 days, including VA pension, child support, social security, disability, and worker's compensation. If self-employed, most recent quarterly tax form and last year's income tax forms.
8. Social security cards for all members of the household.
9. Record of income earned through interest, dividends, rents, royalties, and investment gains.
10. Information concerning school grants and stipends (excluding tuition and books).
11. Receipts relating to monthly expenses, including child care, child support, alimony, utilities, rent or mortgage payments, rent receipts, and/or lease agreements.
12. Payments relating to health, life, and auto insurance.

(continued)

13. Proof of the availability of health insurance from employer(s), if offered, and the amount of premium that is the household's responsibility

14. Payments to medical providers

LIST OF REQUIRED MEDICATIONS

Individual's Name: _____ Date: _____

Please provide the requested information on all medications taken, including those medications covered by other resources

Name of Drug	Strength	Dosage	How Long Will Drug Be Taken	Purpose of Drug	Prescribing Physician	Pharmacy	Cost	Current Method of Payment

APPENDIX S

EMPLOYMENT VERIFICATION FORM

FROM:

TO: _____
EMPLOYER

Phone:
Fax:

Bookkeeping or Personnel:

To determine eligibility, the following information is requested. Please complete all items below. If an item does not apply, put **N/A** in the space provided. Your cooperation is appreciated.

EMPLOYEE: _____
SS # _____ CASE # _____
Date started employment _____
Wages per hour _____
Hours per week _____
Paid weekly or bi-weekly _____
Date of next check _____
Amount of next check _____

TIME FRAME	GROSS WAGES	TIPS	NET WAGES	GARNISHMENTS

Is/Was medical insurance available through employer? YES _____ NO _____
Date after hire medical insurance eligible _____
Did employee sign up for medical insurance? YES _____ NO _____
Date medical insurance became effective _____
Name of medical insurance company _____
Type of medical insurance: family (group) _____ individual _____
Cost of medical insurance per month: family _____ individual _____

Last day of work _____
Date of last paycheck _____
Amount of last paycheck _____
Reason for leaving work _____
Did he/she voluntarily leave employment? YES _____ NO _____

I give my permission to release the above requested information.

PLEASE PRINT

_____
Signature of Employee

_____
Date

_____
County Case Worker

_____
Bookkeeper/Employer

_____
Date

_____
Phone Number

MEDICAL INSURANCE STATUS

In order for a person to be considered for possible financial assistance through Minnehaha County public funding on any medical claims, their medical insurance status must be verified.

Under State Law SDCL 28-13-27 (6c), a person is NOT eligible for public assistance if "they have failed to purchase health insurance which was made available through the individual's employer".

CLIENT:_____ **EMPLOYER:**_____

SOCIAL SECURITY NUMBER:_____ **CASE NO:**_____

***************TO BE COMPLETED BY EMPLOYER****************
(Please check appropriate line)
****

_____**Employer does NOT offer a health care plan to employees.**

_____**Is NOT eligible for health care coverage.**
- _____**Pre-existing health condition.**
- _____**Employee status (non-management).**
- _____**Insufficient employment period.**

_____**Is eligible for health care coverage, but refused.**

_____**Is covered under employer's health care plan.**

If covered or eligible but refused, PLEASE COMPLETE.

Name of Insuror:_____

Policy or group #:_____

Eligible Date of Coverage:_____

Employee's Monthly Premium on Solo Coverage: _____

Employee's Monthly Premium on Family Coverage: _____

Amount of Deductible or Co-Pay: _____

COBRA Monthly Premium:_____

Final Date to Enroll in COBRA:_____

APPENDIX T

VERIFICATION OF MEDICAL NECESSITY

VERIFICATION
OF
MEDICAL NECESSITY

INDIVIDUAL'S NAME: _____

The county has received an application for medical assistance from the above-named individual. In order for this office to proceed, written documentation must be provided to substantiate the medical necessity for the needed medical service

This written documentation must contain enough information to support the need for this referral. By state statute, medical necessity must meet the following criteria:

(1) Consistent with the person's symptoms, diagnosis, condition, or injury;
(2) Recognized as the prevailing standard and consistent with generally accepted professional medical standards of the provider's peer group;
(3) Provided in response to a threatening condition; to treat pain, injury, illness, or infection; to treat a condition which could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;
(4) Not furnished primarily for the convenience of the person or the provider; and
(5) There is no other equally effective course of treatment available or suitable for the person needing the services which is more conservative or substantially less costly.

The county shall rely on the physician's determination as to the medical necessity of a service, unless evidenced exists to the contrary.

Under the provision of SDCL 28-13, non-emergency services must have prior approval from the county, fit the above criteria, and meet the eligibility standards of the county before payment of the services can be approved

Thank you for your assistance in this matter.

CASEWORKER: _____

COUNTY: _____

ADDRESS: _____

_____

_____

_____

APPENDIX U

WORK ABILITY FORM

WORK ABILITY FORM

TO: Medical Provider: _____ FROM: _____
County Caseworker

RE: _____ DOB: _____ CASE#: _____

Information needed for: Current _____ Past 6 months _____ Past 12 months _____

1. Date patient first met with Physician completing this form and date of last visit:

2. Nature of illness/injury & date of onset:

3. Is the patient able to work currently?
   _____ Yes (Are there any restrictions?)

   _____ No (Why not, and when did this start?)

4. Was the patient able to work prior to onset of illness/injury described above?
   _____ Yes (Were there any restrictions?)

   _____ No (Why not, and when did this start?)

5. Is/was the patient able to attend training programs and/or search for employment for the time period noted above? _____ Yes _____ No

6. If patient is/was not able to work or attend training programs/seek employment—when would he/she be able to return to work? Are there any restrictions on their ability to work for the future?

_____ _____ _____
Doctor's Signature Date Phone Number

_____ _____
Print Name Clinic/Facility

08/26/13

APPENDIX V

PRE-AUTHORIZATION ESTIMATE OF COST FORM

PREAUTHORIZATION: ESTIMATE OF COST FOR MEDICAL PROCEDURES

NAME OF CLIENT: _____

CASE NUMBER: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

CASEWORKER: _____

For consideration of medical assistance for life threatening procedures, a written estimate of cost from all medical providers associated with the procedure in question is required. No final decision for financial assistance will be made until all estimates of cost are received. This form is to be given to the medical provider(s) to complete and return to this office.

Procedure needed to verify what? _____

PROCEDURE 1:

Name of medical procedure: _____

Name of Physician(s) performing procedure: _____

Name of facility procedure will take place: _____

ESTIMATE OF COST:

-physician: _____ -labs: _____

-facility: _____ -x-ray: _____

-anesthesiology: _____ -other: _____

PROCEDURE 2:

Name of medical procedure: _____

Name of Physician(s) performing procedure: _____

Name of facility procedure will take place: _____

ESTIMATE OF COST:

-physician: _____ -labs: _____

-facility: _____ -x-ray: _____

-anesthesiology: _____ -other: _____

Signature of person completing form: _____ Date: _____

Title: _____ Phone #: _____

This information can be faxed back to this office at or be mailed/dropped off to the address listed above.

APPENDIX W

PHYSICIAN REVIEW FORM

MEDICAL REFERRAL

DATE: November 21, 2014

NAME: ADDRESS:

DOB: HOSPITAL: **Sanford**
CASE:

ADMIT: **8/26/2014** DISCHARGE: **8/28/2014**

Have Notice of Hospitalization? Y N ACCOUNT #:
Have AFPRA (within 1 yr of admit)? Y N N/A

Available for review are the medical records from: **Sanford USD Medical Center**

Admission diagnosis: _____

_____

Discharge diagnosis: _____

_____

I do: **I do not:** feel this was a necessary and emergency hospital service.

Comments: _____

_____ _____
PHYSICIAN

_____

_____ _____
DATE

_____

28-13-27(2) "Emergency hospital services," treatment in the most appropriate hospital available to meet the emergency need. The physician, physician assistant, or nurse practitioner on duty or on call at the hospital must determine whether the individualo requires emergency hospital care. The need for emergency hospital care is established if the absence of emergency care is expected to result in death, addional serious jeopardy to the individuals health, serious impairment to the individuals bodily functions, or serious dysfunction of any bodily organ or part. The term does not include care for which treatment is available and routinely provided in a clinic or physician's office.

28-13-27.1 Medically necessary hospital services. Medically necessary hospital services are services provided in a hospital which meet the following criteria:

(1) Are consistent with the person's symptoms, diagnosis, condition, or injury;
(2) Are recognized as the prevailing standard and are consistent with generally accepted professional medical standards of the provider's peer group;
(3) Are provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would result in physical or mental function consistent with prevailing standards for the diagnosis or condition;
(4) Are not furnished primarily for the convenience of the person or the provider; and
(5) There is no other equally effective course of treatment available or suitable for the person needing the services which is more conservative or substantially less costly.

A county shall rely on the attending physician's determination as to medical necessity of hospital services unless evidence exists to the contrary.

APPENDIX X

MEDICAL CASEWORKER REFERRAL FORM

MEDICAL REFERRAL

COUNTY _____ COUNTY _____

DATE: _____ CASEWORKER: _____

CASE #: _____ ADDRESS: _____

CLIENT: _____ _____

DOB: _____ CITY: _____

SS#: _____ ZIP: _____

REASON FOR REQUEST

1) HOSPITAL _____

HOSPITAL: _____ ACCOUNT #: _____

DATE OF ADMIT: _____ DATE OF DISCHARGE: _____

COMMENTS: _____

_____

2) PREAUTHORIZATION _____

SPECIFY REQUEST(S) _____

_____

3) INSURANCE _____ 4) WORK ABILITY _____ 5) OTHER _____

SPECIFY REQUEST(S) _____

_____

OBTAIN MEDICAL RECORDS FROM: (if other than hospital request)

_____

_____

_____

(Please enclose Notice of Action and copies of appropriate release of information forms)

COUNTY ACTION ON CASE: APPROVED: _____ DENIED: _____

COMMENTS: _____

_____

HOSPITAL	DOCTOR	LAB	X-RAY
_____	_____	_____	_____
_____	_____	_____	_____

OTHERS _____

_____

APPENDIX Y

AUTHORIZATIONS FOR PAYMENT

AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES

COVERED INDIVIDUAL: _____

SSN: _____

NAME OF PROVIDER: _____

TAX ID NUMBER: _____

DATES OF COVERAGE: _____

LIMITS OF COVERAGE: _____

County payment is limited to the provider's usual and customary charge or the Medicaid rate of payment, whichever is less. Payment is subject to Medicaid's payment methodology. When requesting reimbursement from the county, an itemized bill must include the individual's name, the specific dates of service, the procedure/service provided, the appropriate cpt code, and the provider's usual and customary charge for the procedure/service provided.

Upon accepting this authorization, the medical provider agrees to actively pursue and bill any third party payer for any retroactive benefits that the client may become eligible for and reimburse the county for any funds collected. This authorization gives approval only for the date and service listed. Any additional service or appointment must have pre-authorization or the claim will be denied. The county will not be responsible for any co-payments or deductibles. Acceptance of county payment/client co-payment constitutes payment in full. Balanced billing is prohibited.

AUTHORIZED BY: _____ DATE: _____

COUNTY: _____

ADDRESS: _____

_____

_____

_____

AUTHORIZATION
FOR
PAYMENT OF MEDICATIONS

COVERED INDIVIDUAL: _____

SSN: _____

NAME OF PROVIDER: _____

TAX ID NUMBER: _____

DATES OF COVERAGE: _____

LIMITS OF COVERAGE: _____

EXPIRATION DATE: _____

This authorization is limited to medication needs for a one-month period only. Any refills provided without the county's authorization will be the individual's responsibility. If the county requires a co-pay, the co-pay must be applied monthly.

Payment is limited to the provider's usual and customary charge or the Medicaid rate of payment, whichever is less. When requesting reimbursement from the county, an itemized bill must include the individual's name, the drug provided, the date of service, and the charge. The county assists with amounts that exceed the individual's ability to pay, if any.

Upon accepting this authorization, the medical provider agrees to actively pursue and bill any third party payer for any retroactive benefits that the client may become eligible for and reimburse the county for any funds collected. This authorization gives approval only for the date and service listed. Any additional service or appointment must have pre-authorization or the claim will be denied. The county will not be responsible for any co-payments or deductibles. Acceptance of county payment/client co-payment constitutes payment in full. Balanced billing is prohibited.

AUTHORIZED BY: _____ DATE: _____

COUNTY: _____

ADDRESS: _____

_____

_____

_____

APPENDIX Z

SNAP BENEFIT AMOUNTS (EFFECTIVE 10/1/14)

Ashley

SSI (Effective 01/01/14)		SOCIAL SECURITY (Effective 01/01/14)	FEDERAL MINIMUM WAGE (Effective 07/24/09)
Income	Resource	COLA 1.5%	$7.25 per hour
Single-$721	$2,000	SMI (Medicare Part B) $104.90	
Couple -$1082	$3,000		

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Effective 10/01/14

This chart is to be used as a reference in determining a household's income eligibility. Households containing an elderly or disabled member, as defined in Section 2012, must meet the NET income test (Column 2). All other households must meet BOTH the GROSS and the NET income eligibility tests (Columns 1 and 2).

HOUSEHOLD SIZE	MAXIMUM GROSS INCOME*	MAXIMUM NET INCOME	THRIFY FOOD PLAN
1	$1,265	$973	$194
2	$1,705	$1,311	$357
3	$2,144	$1,650	$511
4	$2,584	$1,988	$649
5	$3,024	$2,326	$771
6	$3,464	$2,665	$925
7	$3,904	$3,003	$1,022
8	$4,344	$3,341	$1,169
9	$4,784	$3,680	$1,315
10	$5,224	$4,019	$1,461
11	$5,664	$4,358	$1,607
12	$6,104	$4,697	$1,753
13	$6,544	$5,036	$1,899
14	$6,984	$5,375	$2,045
15	$7,424	$5,714	$2,191
16	$7,864	$6,053	$2,337
17	$8,304	$6,392	$2,483
18	$8,744	$6,731	$2,629
19	$9,184	$7,070	$2,775
20	$9,624	$7,409	$2,921
21	$10,064	$7,748	$3,067
22	$10,504	$8,087	$3,213
23	$10,944	$8,426	$3,359
24	$11,384	$8,765	$3,505
25	$11,824	$9,104	$3,651
26	$12,264	$9,443	$3,797
For each additional member	+440	339	+146

*Gross income is total income minus verified legally obligated child support payments.

RESOURCE LIMIT
Categorically Eligible: N/A
HH has eligible member over 60 or disabled: $3,250
All other HH: $2,250

Vehicles:
1 vehicle excluded; follow policy for other exclusions

DEDUCTIONS

Child Care:
Households are allowed the amount of dependent care costs they are billed for children under the age of 16.

Medical:
Expenses for elderly/disabled members over $35 and under $201 receive a medical standard; if above $200, actual expense used.

Standard Deduction:
$155 - 1-3 HH memb
$165 - 4 HH memb
$193 - 5 HH memb
$221 - 6 or more HH
(HH members – do not include disqualified, sanctioned, ineligible or non household members)

Effective 10/01/14
Utility Standards:
SUA - $683
LUA - $195
OUA - $ 80
PUA - $ 46

Capped Shelter:
$490

MEDICARE SAVINGS PROGRAM (effective 01/14)

Family Size	QMB 100% of FPL	SLMB 120% of FPL	QI-1 135% of FPL
1	$973	$1,167	$1,313
2	$1,311	$1,573	$1,770
3	$1,650	$1,979	$2,227
4	$1,988	$2,385	$2,684
5	$2,326	$2,791	$3,140
6	$2,665	$3,197	$3,597
7	$3,003	$3,603	$4,054
8	$3,341	$4,009	$4,511

RESOURCE LIMIT
Single - $7,160
Couple - $10,750

LONG-TERM CARE (effective 01/01/14)

Maximum Monthly Income Limit $2,163
Average Monthly Private Pay Rate $190.42

RESOURCE LIMIT
$2,000

SPOUSAL IMPOVERISHMENT

Refer to Section 9700 of the LTC procedures manual. Income limits depend on gross income minus certain expenses
Maintenance Needs Standard for CS: $1891.25 (min) - $2931 (max) (1/1/14) Protected Resource: $23448 (min) - $117,240 (max) 1/1/14

APPENDIX AA

NOTICE OF COUNTY/PATIENT SHARE

NOTIFICATION OF COUNTY ASSISTANCE

CLIENT NAME: _____

DATE OF ADMISSION: _____

ACCOUNT NUMBER: _____

Total Hospital Charges Computed according to SDCL 28-13-29: $ _____

Household Share: $ _____

County Share: $ _____

COMMENTS: _____

_____

_____

_____

_____

_____

CASEWORKER: _____

COUNTY: _____

ADDRESS: _____

_____

_____

FAX: _____

CCPR-NOCA (2002)

APPENDIX BB

REQUEST FOR FINANCIAL INFORMATION

REQUEST FOR FINANCIAL INFORMATION

To Whom It May Concern:

The county is in the process of determining financial eligibility for county assistance for the below-listed individuals. Please complete the following information if any of the individuals have accounts, certificates of deposit, or trusts at your financial institution that are owned solely or jointly by the individual listed.

Individual	Social Security Number

Type of Account	Current Balance	Interest Bearing (yes/no)	Percent of Interest	How Often Interest Paid

If there have been transactions within the last 36 months that resulted in the redemption or transfer of a financial resource, please specify what was transferred, the amount transferred, and the date of the transfer.

An Authorization for the Release of Information is attached. Thank you for your assistance.

CASEWORKER: _____

COUNTY: _____

ADDRESS: _____

Information Provided By: _____ Date: _____

CCPR-RFFI (2002)

APPENDIX CC

CHECKLIST FOR RETROACTIVE MEDICAID

CHECKLIST FOR RETROACTIVE MEDICAID

NAME: _____

SSN: _____ BIRTH DATE: _____

DATE SSI APPROVED: _____

RETROACTIVE DATE: _____

MEDICAID NUMBER: _____

NAME OF INDIVIDUAL CONTACTED AT
MEDICAID PROVIDER UNIT IN PIERRE: _____

DATE OF CONTACT: _____

PROVIDER CONTACTS:

NAME: _____

PHONE CONTACT DATE: _____ Letter: Yes ____ No ____

FOLLOWUP NOTICE DATE: _____

DATE REIMBURSEMENT CHECK RECEIVED FROM PROVIDER: _____

NAME: _____

PHONE CONTACT DATE: _____ Letter: Yes ____ No ____

FOLLOWUP NOTICE DATE: _____

DATE REIMBURSEMENT CHECK RECEIVED FROM PROVIDER: _____

NAME: _____

PHONE CONTACT DATE: _____ Letter: Yes ____ No ____

FOLLOWUP NOTICE DATE: _____

DATE REIMBURSEMENT CHECK RECEIVED FROM PROVIDER: _____

APPENDIX DD

POTENTIAL RETROACTIVE MEDICAID AGREEMENT TO REPAY COUNTY

NOTICE OF POTENTIAL RETROACTIVE MEDICAID CLAIM AND AGREEMENT TO REPAY COUNTY

INDIVIDUAL'S NAME: _____

SSN: _____

The above-named individual has an application pending with the Social Security Administration and/or the Department of Social Services for medical benefits. If you choose to provide medical services and accept payment for those services from the county pending the final determination of eligibility, you must sign this document as an acknowledgement that you agree to the following if the individual is determined to be retro-actively eligible for medical benefits:

(1) Agree to bill Medicaid for those claims incurred during the time the individual is determined to be retro-actively eligible;

(2) Agree to submit the retro-active claims to Medicaid within six months from the date that Medicaid is approved; and

(3) Agree to repay the county for assistance previously paid by the county.

PROVIDER: _____ DATE: _____

Please return this signed form to:

CASEWORKER: _____

COUNTY: _____

ADDRESS: _____

_____

_____

_____

APPENDIX EE

NOTICE OF RETROACTIVE MEDICAID ELIGIBILITY

NOTICE
OF
RETROACTIVE MEDICAID ELIGIBILITY

PROVIDER: _____

This is to advise you that the below-listed individual has been approved for Medicaid benefits. Attached is a copy of the letter confirming the eligibility. Please file your medical claim with the Department of Social Services, Office of Medical Services, as soon as possible.

Remember: Medicaid has specific billing requirements when submitting a claim for retroactive benefits. If you have questions concerning the submission of claims, please contact the Medicaid claims unit at 1-800-452-7691.

INDIVIDUAL'S NAME: _____

SSN: _____

DATE APPROVED FOR MEDICAID: _____

PERIOD OF RETROACTIVE COVERAGE: _____

MEDICAID ID NUMBER: _____

CASEWORKER: _____ DATE: _____

COUNTY: _____

ADDRESS: _____

APPENDIX FF

CATASTROPHIC COUNTY POOR RELIEF (CCPR) SUBMISSION FORMS

Catastrophic County Poor Relief (CCPR)
VOUCHER

VOUCHER NUMBER: INVOICE NUMBER:	INVOICE DATE:
TO:	FROM: Catastrophic County Poor Relief Attn: Kris Jacobsen 211 E Prospect Ave Pierre, SD 57501
DESCRIPTION / JUSTIFICATION:	

I declare and affirm under the penalties of perjury that this claim has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

COMMISSION CHAIR DATE

AUTHORIZATION DATE

AUTHORIZATION DATE

APPLICATION FOR REIMBURSEMENT
CATASTROPHIC COUNTY POOR RELIEF

RESERVED FOR SDACC OFFICE USE

County: _____

Patient Name: _____

Address: _____

_____

DOB: _____

SSN: _____

Diagnosis: _____

_____

_____

Check One: ☐Emergency ☐Pre-Approved Emergency

Date Received: _____

Notice To Board: _____

Board Action Date: _____

Date Paid: _____

Check Number: _____

Comments: _____

_____

_____

Written summary on Patients Eligibility for CCPR program:

Provider	Actual Bill	Amount Paid By County

APPENDIX GG

CCPR PROCEDURE MANUAL – 2010 VERSION

CATASTROPHIC COUNTY POOR RELIEF PROGRAM

PROCEDURES MANUAL

2010 VERSION

For further information contact

Kristie Jacobsen, Administrator
Catastrophic County Poor Relief Program
222 E.Capitol Avenue Suite 1
Pierre, SD 57501
(605) 224-4554
Email: info.sdacc@midconetwork.com

TABLE OF CONTENTS

CHAPTER I – County Participation and Withdrawal

CHAPTER II –Determining Medical Indigence

CHAPTER III – Reimbursements

CHAPTER IV – Assessments

ATTACHMENTS

CHAPTER I

COUNTY PARTICIPATION AND WITHDRAWAL

- ***PURPOSE***

The CCPR program was established under SDCL 28-13A to assist counties with the payment of catastrophic medical expenses incurred on behalf of individuals who are medically indigent and who have no ability or only limited ability to pay the costs of hospitalization.

- ***ADMINISTRATION – HOW TO CONTACT THE BOARD***

The CCPR program is administered jointly by the South Dakota Association of County Commissioners (SDACC) and the Catastrophic County Poor Relief Board (Board). The Board consists of five county commissioners appointed by the executive board of the South Dakota Association of County Commissioners. Board members serve staggered terms of four years or until their term as county commissioner has expired. Issues concerning the CCPR program and contacts with and correspondence to the CCPR Board should be directed to the CCPR Program Administrator (Administrator) at the below address:

Kris Jacobsen, Administrator
Catastrophic County Poor Relief Program
South Dakota Association of County Commissioners
222 E Capitol Ave Suite 1
Pierre, South Dakota 57501
(605) 224-4554

- ***BOARD MEETINGS***

Board meetings are subject to call. To request a meeting with the Board, interested parties should contact the Administrator to schedule a meeting. (§ 22:02:02:01)

If a claim for reimbursement is submitted by a CCPR Board member's county, that Board member may participate in the discussions concerning the claim, but that board member may not participate in the Board's final vote of approval or disapproval. (§ 22:02:02:02)

- ***COUNTY ELIGIBILITY IN THE CATASTROPHIC PROGRAM***

If a county wishes to begin participation in the CCPR program, it must notify the Administrator, in writing, by July 31. (§ 22:02:01:02)

The Administrator and the Board shall review the county's request to participate and shall notify the requesting county, in writing, of its approval status by September 1. If the county's request to participate is denied, the notice shall contain the reasons for the denial and the county will have until October 1 to correct the deficiencies contained in the notice of denial. If approved as a participating county, the county may not begin participation before January 1 of the following year. (§§ 22:02:01:02 and 22:02:01:03)

Once approved as a participating county, the county remains a participating county for successive calendar years until either the county fails to pay a CCPR assessment or the county has submitted a withdrawal request and a new calendar year has begun. (§ 22:02:01:05)

A request to withdraw from the fund must be in writing and must be submitted to the Administrator by July 31. A county submitting a withdrawal request will be removed from participation effective January 1 of the following year. A county that has withdrawn from the CCPR program but wishes to again participate must submit to the Administrator a new request for participation. The request must be in writing and must be submitted to the Administrator by July 31. A county requesting to rejoin the CCPR program may not have any

arrearages due the CCPR fund from previous years of participation. (§§ 22:02:01:06 and 22:02:01:07)

- ***DENIAL OF REQUEST TO PARTICIPATE***

A county may be denied participation in the fund (§ 22:02:01:04) for any of the following reasons:

1. The county has failed to pay any portion of a previous CCPR annual assessment;
2. The county has failed to pay any portion of a previous CCPR supplemental assessment;
3. The county has withdrawn from the fund but failed to pay its final assessment;
4. The county's request to participate did not meet the deadline requirements of § 22:02:01:02; or
5. The county did not correct the deficiencies cited in its notice of denial.

- ***ADVERSE DECISIONS – REVIEW BY BOARD***

Decisions under this program which are adverse to a county may be appealed through the Board's review process. The Administrator will notify a county by certified mail if a decision is made which is adverse to the county. A county wishing to contest an adverse decision may request a meeting with the Board for purposes of reviewing the claim. A request for review must be made to the Administrator within 30 days after the county receives the notice of the adverse decision. On receipt of the request, the Administrator will schedule the review with the Board. At the time of the review, the county must present its arguments in support of the claim. Based on the review, the Board will enter its final decision. Notice of the final decision will be sent to the county within 30 days after the review. (§ 22:02:01:08)

CHAPTER II

DETERMINING MEDICAL INDIGENCE

- ***DEFINITION OF "MEDICALLY INDIGENT"***

Before an individual's claim is eligible for reimbursement from the CCPR fund, the county must have determined that the individual is *"medically indigent."* To be considered *medically indigent*, the individual must meet the following criteria:

1. Requires *medically necessary hospital services* for which no public or private third-party coverage is available to cover the cost of hospitalization. Third-party coverage includes coverage such as insurance, veterans' assistance, Medicaid, or Medicare;

2. Has no ability or only limited ability to pay a debt for hospitalization;

3. Has not voluntarily reduced or eliminated ownership or control of an asset for the purpose of establishing eligibility;

4. Is not *indigent by design*; and

5. Is not a veteran or a member of a Native American tribe who is eligible or would have been eligible for services through the Veterans' Administration (38CFR17.54) or the Indian Health Service (42CFR136.24) if the services would have been applied for within 72 hours of the person's admission.

If an individual fails to meet any one of these tests, he/she is not considered medically indigent and the county is not responsible for the payment of the individual's hospital bill. (SDCL 28-13-1.3; 28-13-32.3)

- ***MEDICALLY NECESSARY HOSPITAL SERVICES***

Services billed to the county for an individual who is *medically indigent* must be *"medically necessary."* In order to be considered *medically necessary*, the services must meet the following criteria:

1. The services must be consistent with the person's symptoms, diagnosis, condition, or injury;

2. The services must be recognized as the prevailing standard and must be consistent with generally accepted professional medical standards of the provider's peer group;

3. The services must be provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;

4. The services must not be furnished primarily for the convenience of the person or the provider; and

5. There may be no other equally effective course of treatment available or suitable for the person needing the services which is more conservative or substantially less costly.

This is the same test which hospitals must use when determining medical necessity for a Medicaid recipient. A county must rely on the attending physician's determination as to medical necessity *unless evidence exists to the contrary*. (SDCL 28-13-27.1)

- ***INDIGENT BY DESIGN***

A person may not be considered medically indigent if the person is *"indigent by design."* A person is indigent by design if the individual meets any one of the following criteria:

1. The individual is able to work but has chosen not to work; *[The individual must be employable and must have* ***CHOSEN*** *not to work. This will not affect those individuals who are between jobs through no fault of their own. It will, however, affect those who have voluntarily terminated their employment before acquiring another job. A county needs to be realistic when making this determination. An individual who is chronically mentally ill or who has a history of long-term alcohol or drug abuse may, quite simply, be "unable" to work.]*

2. The individual is a student at a postsecondary institution and has chosen not to purchase health insurance;

3. The individual has failed to purchase health insurance that was made available through the individual's employer; *[A county must be realistic when making this determination. It would be normal to expect that the employee would participate in the employer's health plan. It may not, however, be possible for the individual to purchase the additional family coverage due to the cost.]* or

4. The individual has transferred resources for the purpose of establishing eligibility for medical assistance. When making this determination, the lookback period includes the 36-month period immediately prior to the onset of the individual's illness and continues through the period of time for which the individual is requesting county assistance.

An individual who is determined to be *"indigent by design"* is ineligible for medical assistance and no other criteria may be used to determine eligibility. (SDCL 28-13-27(6); 28-13-32.10)

- ***EMERGENCY vs NON-EMERGENCY***

Hospital services are divided into *"emergency"* and *"non-emergency"* services. If the hospital services are emergency services, the physician, physician's assistant, or nurse practitioner on duty or on call at the hospital must determine whether the individual requires emergency hospital care. The need for emergency hospital care is established if the absence of emergency care is expected to result in death, additional serious jeopardy to the individual's health, serious impairment to the individual's bodily function, or serious dysfunction of any bodily organ or part. The term does not include care for which treatment is available and routinely provided in a clinic or physician's office. (SDCL 28-13-27(2))

If the hospital service is not an emergency and the county is involved as a payer, state law requires that the affected county must approve non-emergency hospital services ***before*** the services are provided. (SDCL 28-13-33)

Regardless of the type of case, a county always has the right to review the case before accepting responsibility for payment or before paying the claim. As part of the review, the county may request assistance from the Department of Social Services. Requests for such assistance must be directed to the Department of Social Services/Medical Review. In any

event, any review conducted must be done under the supervision of a licensed physician. (SDCL 28-13-37.1)

- ***VETERANS AND NATIVE AMERICANS***

With respect to veterans and Native Americans, there has been a change in the way counties and hospitals do business. An individual will not qualify as medically indigent if the individual is eligible or would have been eligible for VA or IHS assistance ***if the services had been applied for within 72 hours of the individual's admission.*** (38CFR17.54 & (42CFR136.24) Effective July 1, 1997, the hospital must inquire whether the individual is a veteran or a member of a Native American Tribe (SDCL 28-13-34.1(8)). If the response to either of these inquires is "yes," it is the hospital's responsibility to pursue eligibility through the VA or IHS. Counties are encouraged to assist the hospital in working through these particular cases. Keep in mind that a veteran may not be eligible on the day of admission but may actually become eligible during his/her hospital stay due to the cost of care and the resulting reduction in net worth. It, therefore, becomes very important that hospitals and counties work together in monitoring these cases very closely.

A veteran who is eligible for medical care through the Veterans' Administration (VA) and enters a hospital, other than an available VA hospital, for emergency care is ineligible for county benefits.

A veteran who enters a hospital, other than a VA hospital, for emergency care who is determined to be ineligible for reimbursement while at the hospital but who would be eligible once stabilized and transferred to a VA facility, may be eligible for county assistance for the inpatient days during which the veteran was not stable enough to be transferred, providing

the veteran is determined to be medically indigent under the provisions of SDCL chapter 28-13.

At the point the veteran can be transferred, the veteran is no longer considered eligible for county benefits and the county's obligation ends.

- ***EXPERIMENTAL PROCEDURES/MODES OF TREATMENT***

State law now makes it very clear that no county is liable for the payment of any experimental procedures or experimental modes of treatment. (SDCL 28-13-33.1)

- ***HOSPITAL TO OBTAIN RELEASE OF INFORMATION FROM PATIENT***

When submitting a notice of hospitalization, the hospital must make every reasonable effort to secure from the patient ***and to include with the notice***; a release of medical information form that has been signed by the patient or the patient's authorized representative. The form must authorize the release of information concerning the patient or members of the patient's household to the patient's county of residence. (SDCL 28-13-34.2)

The form to be used for this purpose has been developed in cooperation with the South Dakota Association of Healthcare Organizations. The form has been made available to all South Dakota hospitals for their use in meeting the requirements of SDCL 28-13-34.2.

Copies of both of the form may be found in **Appendix B** of the Welfare Manual. A hospital is not required to use the specific form; however, any release supplied to the county must contain the information specified on the form.

If a county needs to obtain either financial or medical information on the patient or the patient's household, the county must supply a copy of the appropriate release to the agency, person, or institution and must specify in writing what information the county is seeking.

Again, the Release of Medical Information form and the Release of Financial Information form can be found in **Appendix B and Appendix C** of the Welfare Manual.

- ***HOSPITAL TO EXHAUST OTHER PAYMENT SOURCES***

In the end, before a hospital can submit a bill to a county, state law requires the hospital to exhaust other payment sources, including accepting "reasonable" payments from the patient. While "reasonable" is certainly open to interpretation, the hospital should attempt to establish a payment plan that is reasonable when considering the household's income and other debt and the amount of the hospital bill. When submitting a claim to a county, the hospital must be able to demonstrate that it has met this criterion. (SDCL 28-13-33.2)

- ***ABILITY TO PAY***

When determining whether a person is eligible for medical assistance through the county, the county must determine what income and resources are available to the household. The county must calculate the household's monthly expenses and must then use the formula established in statute that calculates whether the individual has any ability to pay the hospital bill. These calculations must be made according to SDCL 28-13-32.5 to 28-13-32.9, inclusive.

The form used to determine whether a person has any ability to pay the hospital bill may be found at **Appendix E** in the Welfare Manual. Please refer to the statewide guidelines on county poor relief for detailed information on how to complete this form.

Once a county determines that an individual has an ability to pay all or part of the cost of hospitalization, the county must notify the hospital. The notice should include the amount payable by the patient and the amount payable by the county, if any.

CHAPTER III

REIMBURSEMENTS

- **COUNTY TO PURSUE THIRD-PARTY PAYMENT SOURCES**

Because the county is the payor of last resort, a county must pursue the availability of a third-party payment source before accepting responsibility for a catastrophic claim. A third-party payment source is the obligation of an entity other than the county for either partial or full payment of the medical cost of injury, disease, or disability. Third-party payment sources include coverage such as Medicare, Medicaid, private health insurance, workers' compensation, supplemental security income, disability insurance, and automobile insurance.

The county must be able to document pursuit of the availability of a third-party payment source. The documentation must be maintained in the individual's record. When the claim is subsequently submitted to the CCPR program for payment, evidence of the third-party payment or rejection must accompany the claim. (§ 22:02:02:10)

- ***COUNTY PAYMENT GOVERNED BY COST STATEMENT OR MEDICAID RATE***

Effective July 1, 1997, the county's rate of reimbursement to a hospital is the actual cost of hospitalization determined according to the hospital's cost statement or the amount payable under the state's Medicaid system, whichever is lower. (SDCL 28-13-29) Also effective July 1, 1997, the responsibility for reviewing, approving, and maintaining copies of the hospitals' cost statements was transferred to the Department of Social Services. Questions relating to a hospital's cost statement or requests for copies of cost statements should be directed to the following office:

Office of Provider Reimbursement & Audits
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501 (605) 773-3643

Hospital claims covering both in-patient and same-day surgery cases must be submitted on both a UB-04 form and on the billing form which breaks out the hospital's ratio of costs to charges for the county. To obtain the Medicaid pricing information, both of these forms must be forwarded to the South Dakota Department of Social Services at the below address:

South Dakota Department of Social Services/Medical Services
Premium Assistance
700 Governors Drive
Pierre, South Dakota 57501

Once a claim is priced, the South Dakota Department of Social Services will return the claim to the County with the Medicaid pricing information attached. It is the county's responsibility to maintain this pricing information in the individual's file. If county payment is based on the Medicaid price, these documents constitute the evidence for the Medicaid pricing. The Department **does not** maintain copies of these documents. If a hospital questions the pricing, it is the county's responsibility to produce the documentation that substantiates the calculated price and to relay the pricing information back to the hospital.

- ***COUNTY TO NOTIFY DEPARTMENT OF IMMINENT CLAIM***

As soon as it appears to a county that the possibility of a catastrophic claim exists, the county is required to notify the Catastrophic Program. Notification may be made either in writing or via a telephone call to the Administrator. (§ 22:02:02:03)

- ***BENEFIT PERIOD***

Reimbursement from the CCPR fund for medical expenses is limited to those medical expenses that an individual has incurred over a 12-month period. This 12-month period is referred to as the individual's "benefit period." The 12-month benefit period begins with the first day an eligible individual incurs hospital or other medical expenses, as long as those expenses are used in establishing or computing a CCPR payment. (§ 22:02:02:04)

> ***EXAMPLE:*** Joe is medically indigent and incurred miscellaneous medical expenses beginning July 15, 1997. On August 13, 1997, Joe was involved in an accident. He was hospitalized and incurred additional, major medical expenses as a result of the accident. Joe continued to incur medical expenses throughout the next 14 months. Even though the county began paying Joe's medical bills in July, the county could chose to limit its request for reimbursement for those medical claims which began on August 13, rather than July 15. If the county chooses August 13 as the starting date, the 12-month benefit period expires at midnight August 12, 1998. If the county chooses July 15 as the starting date, the 12-month benefit period expires at midnight July 14.

- ***COUNTY APPLICATION FOR REIMBURSEMENT***

A county wishing to request reimbursement from the CCPR fund should do so on an Application for Reimbursement form which is available from the SDACC. **(Appendix CC)**

The county should complete the Application for Reimbursement and return it, together with the necessary documentation/evidence, to the Administrator.

The amount of requested reimbursement for each provider should show the amount billed by the provider, the amount actually paid by the county, the required deductions ($20,000 + 10% county share), and the balance due from the CCPR fund. Regardless of the amount paid, the rate of reimbursement from the fund for a hospital expense incurred after June 30, 1997 may not exceed the hospital's ratio of cost to charge or the Medicaid rate of reimbursement, whichever is lower. (§ 22:02:02:08)

EXAMPLE:

	Actual Bill	Paid by County
Sioux Valley Hospital	40,000.00	28,000.00
St. Mary's Hospital	60,000.00	51,000.00
Smith's Medical Supplies	2,000.00	1,700.00
Bill's Pharmacy	700.00	595.00
TOTALS	102,700.00	81,295.00
LESS:		
County Deductible		-20,000.00
County Share (10% of balance)		-6,129.50
Balance to be Paid by CCPR Fund		$55,165.50

If the county determined that the individual had an ability to pay part of the hospital bill, the amount contained in the "Paid by County" column must reflect the county's share after deducting the client's share.

The county must provide evidence that will substantiate the claim, the dates of service, the individual's and the county's share of the bill, and the amount paid by the county. Evidence supporting the individual's and county's share must consist of a copy of the county's calculations made on the "ability to pay" form. **(Appendix E)** If county payment to a hospital was based on the Medicaid rate, the county must include a copy of the documentation from Medicaid that calculates the Medicaid payment rate. In order to expedite payment, the county should also transmit a voucher that has been signed in the lower left-hand corner by either the county board chair or vice-chair. **(Appendix DD)**

A county may submit more than one voucher per individual but one voucher may contain claims for only one individual. A copy of the voucher will be returned to the county.

If this is the county's first claim on behalf of an eligible individual, the evidence submitted by the county will need to show that the county has met its $20,000 share of the expenses for the individual for the 12-month period in which the services were provided. (§ 22:02:02:05)

If a county carries an individual into a new 12-month benefit period, the individual's medical expenses for the new 12-month period must again exceed $20,000 before his/her medical expenses would again be eligible for reimbursement from the fund. (§ 22:02:02:08)

- ***CLAIMS INVOLVING CHILDREN BORN AS PART OF A MULTIPLE BIRTH***

Children born as a result of a multiple birth (twins, triplets, etc.) who incur medical expenses as a result of that birth are considered to be a single individual when applying the provisions of SDCL 28-13A-6 and 28-13A-7:

> **28-13A-6. Reimbursement from fund – Eligibility – Application.** Any participating county which has incurred hospital and other medical claims in excess of twenty thousand dollars for any individual eligible for county poor relief in a twelve-month period may apply to the board for funds from the catastrophic county poor relief fund. The application shall include such information as the board of catastrophic county poor relief may prescribe.
>
> **28-13A-7. Amount of reimbursement.** The catastrophic county poor relief board shall determine if the application is in order and the claim is justified and may approve disbursements to the county for ninety percent of any hospital and other medical claim payments the county has made for the individual in excess of twenty thousand dollars in the twelve-month period and may continue to reimburse the county for ninety percent of hospital and other medical claim payments for the individual for the remainder of that period.

If a county has a claim involving a multiple birth, the children's expenses are considered together and the total bill for both/all the children is subject to only one $20,000 deductible. In other words, in this particular instance only, a county paying for the birth of twins can

request reimbursement for both children while only making one $20,000 deductible payment. Two for the price of one!

Additional claims submitted for these multiple-birth children for the remainder of the 12-month benefit period are not subject to another $20,000 deductible. When the initial 12-month period ends, each child is considered as a separate individual and each child's medical claim is subject to a $20,000 deductible.

WARNING: Since the state expanded its Medicaid coverage groups, the Catastrophic Program has seen very few, if any, claims for children. If a county receives a notice from a hospital, and the notice involves a child, the county *must be* pro-active. The recommendation is that the county immediately make sure that the family has applied for assistance through the Department of Social Services. In addition, if there is a possibility that the child will require long-term hospitalization or has a long-term disabling condition, an application must be made immediately to the Social Security Administration. If the county fails to investigate these other payment sources, the claim may be denied by the CCPR Board if a determination is made by the Board that the child would have been eligible for benefits through another payment source but the county failed to act. (§ 22:02:02:07)

- ***ORGAN TRANSPLANTS***

When an organ transplant is involved, a county must ensure that the requirements of SDCL 28-13A-13 have been met before the county accepts responsibility for the expenses. SDCL 28-13A-13 contains the following provisions:

> **28-13A-13. Conditions for disbursement for organ transplants.** The catastrophic county poor relief board may not approve a disbursement for care related to an organ transplant unless the county making application establishes the following:

(1) That the same care is available to nonindigent residents of the county. This may be established by the receipt of letters from six insurance companies doing business in the state verifying that insurance coverage is available for such care;

(2) That the care will not jeopardize the funding of health care services already available within the county;

(3) That the care is reasonable and necessary;

(4) That the care provider has determined that the individual in need of the organ transplant is medically, psychologically and socially qualified to receive the transplant according to criteria established by the care provider; and

(5) That there is a reasonable expectation that there will be a significant improvement in the individual's duration or quality of life as a result of the transplant.

Evidence of compliance with SDCL 28-13A-13 will be requested at the time reimbursement is requested through the CCPR fund. *(Don't forget to notify the CCPR Program when an organ transplant is imminent.)*

It is strongly recommended that the county enter into a written agreement with the facility performing the transplant so the extent of the county's responsibility is very clear. If the county intends that the maximum amount stated includes ***all*** of the expenses relating to the transplant (the actual surgery and hospitalization; physician fees; housing; follow-up, etc.) the county should specify such in the agreement.

- ***DOCUMENTS TO BE TRANSMITTED WITH CLAIM***

When a county submits a claim for reimbursement, the following documents must be submitted with the claim:

1. A completed Application for Reimbursement;
2. A copy of the hospital bill showing the dates of service and the charges;
3. A copy of the UB-04 pricing scheme if the county paid the hospital bill based on the Medicaid rate;

4. The application for county assistance or the completed ability to pay form that contains the individual's and the county's share of the hospital bill;

5. Evidence that the county has paid the bill, together with an indication as to the amount paid;

6. If the claim is for an organ transplant, evidence of compliance with SDCL 28-13A-13;

7. Evidence that the county has paid its $20,000 +10 percent share; and

8. A voucher which has been signed by either the county board chair or vice chair.

If, within the same 12-month period, the county submits subsequent claims on behalf of the same individual, the county does not have to re-establish the fact that the county has met its $20,000 share of the expenses.

- ***NEGOTIATING WITH OTHER MEDICAL PROVIDERS***

If a county chooses to pay a medical provider other than a hospital, the county is encouraged to negotiate the rate of reimbursement with the medical provider. If a county is successful in its attempts to negotiate a claim down, the CCPR fund will reimburse 90 percent of the negotiated amount, less the $20,000 share, if applicable.

Experience to date has shown that other medical providers will, and do, provide a percentage reduction for county poor bills. Some counties utilize the Medicaid rate of payment while others have a pre-arranged agreement with the medical provider under which the provider agrees to accept a 25 – 50 percent reduction in billed charges if the county agrees to participate in the payment of the claim.

- ***CLAIM APPROVAL***

On receipt of a completed application and the supporting documentation, the Administrator reviews the request and forwards a recommendation as to the approval, denial, or amendment of the claim to the CCPR Board. If a county's application for reimbursement and/or the accompanying documents contain insufficient information or evidence with which to make a decision as to claim eligibility and/or the amount of the CCPR reimbursement, the Administrator will notify the county and will hold the claim until the necessary supporting documentation is submitted.

The following procedures are used when approving, denying, or amending a claim: A copy of the claim submitted for reimbursement together with the claim documentation and the Administrator's recommendation is sent to each CCPR board member. Each board member reviews the claim and notifies the Administrator, in writing, of the board member's recommended approval, denial, or adjustment of the claim. Final action on the claim is based on the responses received from the board, as long as a majority of the board has responded. If there is disagreement among the responding board members as to whether a claim should be approved, denied, or adjusted, a board meeting is held. If unanimous approval cannot be reached at that time, action on the claim will be as per majority rule. Once there is Board approval, reimbursement is usually made within 90 working days. (§ 22:02:02:06)

- ***CLAIM DENIAL***

The board may deny a county's claim for reimbursement for any of the following reasons:

1. The county has not paid its CCPR annual assessment;
2. The county has not paid its supplemental CCPR fund assessment;

3. The county has not paid the first $20,000 for the individual for the 12-month benefit period;

4. The county has not provided the evidence required under § 22:02:02:05;

5. The service was provided before January 1, 1985;

6. The service was provided before the date of county participation;

7. The county has not been approved as a participating county;

8. The request for reimbursement has been delayed and the county failed to notify the department according to § 22:02:02:03;

9. The claim is for an organ transplant but the county has failed to meet the requirements of SDCL 28-13A-13;

10. The county failed to follow its guidelines when determining eligibility;

11. The county failed to pursue other third-party payment sources;

12. The individual was not eligible for county poor relief; or

13. The claim exceeds the payment limits established in § 22:02:02:08.

If the Board denies the claim, the Administrator shall notify the county of the claim denial. The notice of denial will be in writing, will contain the reasons for the denial, and will be sent by certified mail. (§§ 22:02:02:06 and 22:02:02:07)

- ***ADVERSE DECISIONS – REVIEW BY BOARD***

Decisions under this program that are adverse to a county may be appealed through the Board's review process. The Administrator will notify a county by certified mail if a decision is made which is adverse to the county. A county wishing to contest an adverse decision may request a meeting with the Board for purposes of reviewing the claim. A request for review must be made to the Administrator within 30 days after the county receives the notice of the adverse decision. On receipt of the request, the Administrator will schedule the review with the Board. At the time of the review, the county must present its arguments in support of the

claim. Based on the review, the Board will enter its final decision. Notice of the final decision will be sent to the county within 30 days after the review. (§ 22:02:01:08)

- ***LIENS***

A county has the ability to pursue reimbursement for relief furnished by filing a lien and pursuing other third-party payment sources. ***A reimbursement to the county as a result of a lien or other third-party collection does not release the county's obligation to repay the CCPR fund for those medical expenses previously reimbursed from the fund.*** When filing a lien, the amount of the lien filed must be for the full amount paid by the county without regard to any reimbursement from the CCPR fund. (SDCL 28-14-5)

- ***REIMBURSEMENT TO CCPR FUND WHEN COUNTY COLLECTS ON COUNTY POOR RELIEF CLAIMS***

If a county had previously received a CCPR fund reimbursement for an individual's medical claims and the county subsequently collected either all or part of the claim from the individual or a third party, the county must reimburse the CCPR fund for its pro rata share. Once a collection is made, the county should notify the Administrator of the amount collected. The Administrator will then calculate the county/CCPR share and notify the county of the amount that must be reimbursed to the CCPR fund. When making the calculation, the percentage of the collection to be repaid must equal the percentage of the claims that the CCPR reimbursement represents. (§ 22:02:02:09)

CHAPTER IV

ASSESSMENTS

- ***ANNUAL ASSESSMENTS***

Each January, the Administrator will determine how much money is needed to replenish the CCPR fund and will compute the annual assessment for each participating county. The annual assessments are subject to board approval and once approved, the Administrator will inform the county auditors of each participating county of the amount of that county's annual assessment. The computation is based on the following statutory provision:

> ***28-13A-9. Computation of counties' shares.*** Each participating county's share of the catastrophic county poor relief fund shall be computed utilizing the following factors:
>
> (1) The percent of the total population, minus individuals eligible for medicaid, of the participating counties in the state which reside in the county; and
>
> (2) The percent of the taxable value of the participating counties in the state associated with the county as determined by the department of revenue.
>
> Each participating county's share of the catastrophic county poor relief assessment shall be calculated by multiplying the average of the two factors by the total assessment.

A county must remit its share of the annual assessment to the South Dakota Association of County Commissioners on or before March 15th.

- ***ANNUAL ASSESSMENT – NEW COUNTIES***

A county is not subject to an annual assessment until after its first year of participation. (§ 22:02:03:02)

> ***EXAMPLE***: On June 15, 1996, County "A" requested permission to join the CCPR pool. The Board approved the request and County "A" became a participating member of the pool effective January 1, 1997. County "A's" first annual assessment was not levied until January 1998.

- ***SUPPLEMENTAL ASSESSMENTS***

If it appears to the Administrator that the CCPR fund is in danger of being depleted, the Administrator may recommend to the Board that a supplemental assessment be levied on each participating county. The amount of the supplemental assessment is to insure the availability of funds for pending claims and does not necessarily have to bring the fund balance back to the level established at the beginning of the calendar year. Supplemental assessments are subject to Board approval and once approved, the Administrator sends a written notice to each participating county informing them of the amount of the supplemental assessment due.

The county must remit its share of the supplemental assessment to the South Dakota Association of County Commissioners within 30 days after the county's next scheduled commission meeting following receipt of the notice that a supplemental payment is due. (§ 22:02:03:03)

- ***SUPPLEMENTAL ASSESSMENTS – NEW COUNTIES***

A county that has just begun participating in the CCPR pool and has yet to pay an annual assessment for its first year of participation ***is liable*** for the payment of a supplemental assessment. (§ 22:02:03:03)

> ***EXAMPLE***: County "A" began participating in the CCPR pool on January 1, 1997. On September 29, 1997, the Board levied a supplemental assessment. County "A" ***is liable*** for the payment of its share of the supplemental assessment even though the county has yet to pay an annual assessment.

If a county serves notice on the CCPR Board (by July 31) that it wishes to begin participation in the CCPR Program, that county is not liable for the payment of any

supplemental assessments until it actually begins participating in the program. (§ 22:02:03:03)

> ***EXAMPLE***: County "A" requested permission to join the CCPR pool on June 15, 1996. The Board levied a supplemental assessment on September 5, 1996. County "A" ***is not liable*** for the payment of the supplemental assessment because it will not begin participating in the CCPR Program until January 1, 1997.

- ***SUPPLEMENTAL ASSESSMENTS – WITHDRAWING COUNTY***

If a county has served notice (by July 31) of its intention to withdraw from the CCPR Program, the county remains liable for the payment of any supplemental assessments which may be levied through the end of the county's year of participation. (§ 22:02:03:03)

- ***FINAL ASSESSMENTS – WITHDRAWING COUNTY***

If a county has served notice (by July 31) of its intention to withdraw from the CCPR fund, the withdrawing county is subject to a final assessment. This final assessment is levied at the same time as the annual assessment and constitutes the last, or "final", annual assessment for the withdrawing county. This final assessment is payable to the South Dakota Association of County Commissioners on or before March 15th of the county's first calendar year of non-participation.

> ***EXAMPLE:*** County "C" notified the CCPR Board on July 15, 1997, that it wished to withdraw from the CCPR program. County "C" became a non-participating county on January 1, 1998 and was liable for a final assessment. This final assessment was levied by January 31, 1998 and was payable to the South Dakota Association of County Commissioners on or before March 15, 1998.

- ***FINAL ASSESSMENTS – DISCONTINUANCE OF FUND***

The CCPR fund will be discontinued if, at the end of any calendar year, less than 35 counties elect to remain in the fund. If it becomes necessary to discontinue the fund, a final

assessment will be made against all of the counties that were participating during the final year of the program. The appropriate statutory provision follows:

> **§ 28-13A-5. Discontinuance - Disposition of fund.** If at the end of any calendar year less than thirty-five counties elect to remain in the fund, the fund shall be discontinued and the reserve shall revert to the counties that were in participating in the fund before the fund was discontinued. If the fund balance is negative when the fund is discontinued, a final assessment shall be made on all the counties that were participating in the fund before the fund was discontinued to bring the fund balance to zero. *(Pending Legislative approval of statutory change)*

This final assessment will not be levied until the Administrator is reasonably certain that all claims against the CCPR fund have been submitted and paid. When this final assessment is made, it will be payable to the South Dakota Association of County Commissioners within one year after the assessment is levied. (§ 22:02:03:04)

> ***EXAMPLE:*** The Administrator determines on December 31, 2000 that less than 35 counties will be remaining in the CCPR pool for the next calendar year. As per statutory provisions, the program is automatically discontinued. The Administrator makes the last reimbursements from the fund on May 18, 2001. On June 1, 2001, the Administrator computes the final assessment and notifies each of the counties that were participating on December 31, 2000. This final assessment is payable to the South Dakota Association of County Commissioners by June 1, 2002.

- ***FAILURE TO PAY ASSESSMENT***

If a county fails to pay an assessment, the Administrator will send a written notice to the county auditor. Copies of the notice will be sent to each of the county's commission members as well as each CCPR board member. Except in the case of a final assessment due to discontinuance of the fund, the notice will inform the county that failure to pay the assessment within the time specified in the notice will result in ineligibility.

If a county withdraws from the fund and fails to pay its final assessment, the county is not eligible for readmission to the fund until its arrearages are paid. If a participating county fails to pay an assessment, the county is not eligible to receive reimbursements from the fund until the county's arrearages are paid.

CHAPTER 22:02:01

COUNTY PARTICIPATION AND WITHDRAWAL

22:02:01:01. Definitions. Terms used in this article mean:

(1) "CCPR," the catastrophic county poor relief program established by SDCL 28-13A;

(2) "Board," the Board of Catastrophic County Poor Relief;

(3) "Association," the South Dakota Association of County Commissioners;

(4) "Annual assessment," the assessment made by the board in January of each year against a participating county;

(5) "Supplemental assessment," an assessment made by the board against each participating county when it anticipates that the CCPR funds remaining in a given calendar year will be insufficient to meet predicted obligations for the remainder of the current calendar year; and

(6) "Final assessment," for a withdrawing county, the assessment made by the board against the county which is used to reimburse that county's share of the CCPR fund from the previous calendar year; for a county participating at the time the program ends, the assessment made by the board against each of the remaining participating counties which will bring the fund balance back to the $500,000 level.

Source: 11 SDR 144, effective May 2, 1985; 25 SDR 69, effective November 12, 1998; transferred from § 67:19:01:01, 36 SDR 27, effective August 26, 2009.

General Authority: SDCL 28-13A-4.

Law Implemented: SDCL 28-13A-4, 28-13A-5.

Cross-Reference: CCPR appropriation, SL 1984, ch 204, § 6.

22:02:01:02. County request to participate -- Beginning date of participation. A county wishing to participate in the CCPR program must notify the board, in writing, by July 31. If approved as a participating county, the county may not begin participation before January 1 of the following year.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; transferred from § 67:19:01:02, 36 SDR 27, effective August 26, 2009.

General Authority: SDCL 28-13A-4.

Law Implemented: SDCL 28-13A-4.

Cross-Reference: Reasons for denial of request to participate, § 22:02:01:04.

22:02:01:03. Notice of approval to participate. The board and association shall review the requests submitted under § 22:02:01:02 and shall notify the requesting county, in writing, of its approval status by September 1.

If the county's request for participation is denied, the notice shall contain the reason for the denial.

Counties which have been denied participation have until October 1 to correct the deficiencies contained in the notice of denial.

Source: 11 SDR 144, effective May 2, 1985; 25 SDR 69, effective November 12, 1998; transferred from § 67:19:01:03, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

Cross-Reference: Review procedure, § 22:02:01:08

22:02:01:04. Reasons for denial of request to participate. The board may deny a county's request to participate in the CCPR program for any of the following reasons:

(1) The county has failed to pay any portion of a previous CCPR annual assessment;
(2) The county has failed to pay any portion of a previous CCPR supplemental assessment;
(3) The county has withdrawn from the program but failed to pay its final assessment;
(4) The county's request to participate did not meet the deadline requirements of § 22:02:01:02; or
(5) The county did not correct the deficiencies cited in its notice of denial.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; transferred from § 67:19:01:04, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

Cross-References: Notice of approval to participate, § 22:02:01:03; Assessments, ch 22:02:03.

22:02:01:05. Automatic renewal of participation. Once approved as a participating county, the county is a participating county for successive calendar years until the January 1 after the county submits a withdrawal request according to § 22:02:01:06 or until the county fails to pay a CCPR assessment.

Source: 11 SDR 144, effective May 2, 1985; 19 SDR 76, effective November 23, 1992; transferred from § 67:19:01:05, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

Cross-Reference: Failure to pay assessment, § 22:02:03:05.

22:02:01:06. Request for withdrawal -- Effective date of withdrawal. A participating county wishing to withdraw from the CCPR program shall submit a withdrawal request to the

board by July 31. Counties submitting withdrawal requests shall be removed from participation effective January 1 of the following year.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; transferred from § 67:19:01:06, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-6, 28-13A-7.

Cross-Reference: Final assessments, § 22:02:03:04.

22:02:01:07. Reapplications. A county which has withdrawn from participation in the CCPR program and wishes to again participate shall comply with § 22:02:01:02. To receive board approval, the county may not have any arrearages due the CCPR fund from previous years of participation.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; transferred from § 67:19:01:07, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

Cross-Reference: Reasons for denial of request to participate, § 22:02:01:04.

22:02:01:08. Review procedure. When the board renders an adverse decision under this article, it shall notify the county concerned within 10 working days after the decision is rendered. Notification shall be by certified mail. A county wishing to contest an adverse decision may request the board to review the decision. A review is held under the provisions of SDCL 1-26. A request for a review must be sent to the association within 30 days after receiving the notice of the decision. The association shall schedule the review before the board and shall notify the county. At the time of the review, the county shall present its arguments in support of the claim. Based on the review, the board shall enter its final decision. The board shall send written notice of its final decision to the county within 30 days after the review.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; 22 SDR 2, effective July 17, 1995; transferred from § 67:19:01:08, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

CHAPTER 22:02:02

REIMBURSEMENTS

22:02:02:01. Board meetings. Board meetings are subject to call. Interested individuals must contact the association or a CCPR board member to request a meeting with the board.

Source: 11 SDR 144, effective May 2, 1985; 19 SDR 76, effective November 23, 1992; transferred from § 67:19:02:01, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

22:02:02:02. Board member conflict of interest. If a claim for reimbursement is submitted from a board member's county, that board member may participate in the discussions concerning the claim but may not participate in the board's final vote of approval or disapproval.

Source: 11 SDR 144, effective May 2, 1985; transferred from § 67:19:02:02, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

22:02:02:03. Notice of imminent claim -- Deadline for notifying board of amount of delayed claim. A county shall notify the association in writing as soon as possible if a claim appears to be imminent. If the county's application for CCPR fund reimbursement for the claim is going to be delayed, the county shall provide written notification to the association of the amount of the claim no later than the end of the calendar year following the year the county is billed for the medical expenses.

Source: 11 SDR 144, effective May 2, 1985; transferred from § 67:19:02:03, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

22:02:02:04. Determination of 12-month period. A 12-month period begins the first day an eligible individual incurs hospital or other medical expenses used in establishing or computing

a CCPR payment. A 12-month period ends at 12:01 a.m. on the anniversary of the first date the expenses were incurred.

Source: 11 SDR 144, adopted May 2, 1985, effective July 1, 1985; 19 SDR 76, effective November 23, 1992; transferred from § 67:19:02:04, 36 SDR 27, effective August 26, 2009.

General Authority: SDCL 28-13A-4.

Law Implemented: SDCL 28-13A-4.

22:02:02:05. Application for reimbursement -- Evidence of payment. A county requesting reimbursement from the CCPR fund must submit an application for reimbursement to the association on a form available from the association.

In addition to the application, a county must provide the following information to the association:

(1) A copy of the provider's invoice showing dates of service;

(2) Evidence, such as a copy of the approved county voucher, that payment was made by the county, including the amount paid;

(3) If the request for reimbursement is for a hospital claim incurred after June 30, 1997, documentation which establishes both the individual's and the county's share of the hospital bill;

(4) If county payment to a hospital was based on the Medicaid rate, a copy of the documentation from Medicaid which calculates the Department of Social Services payment rate; and

(5) A voucher signed by the county board of commissioners chair or vice-chair.

If the claim being submitted is the first reimbursement request covering a particular individual, the county must also submit evidence which shows that the county has met its $20,000 share of the expenses for that individual for the 12-month period in which the services were rendered.

If the claim is for an organ transplant, the county must submit evidence of compliance with SDCL 28-13A-13.

Source: 11 SDR 144, effective May 2, 1985, amended effective July 1, 1985; 13 SDR 134, effective March 30, 1987; 19 SDR 76, effective November 23, 1992; 25 SDR 69, effective November 12, 1998; transferred from § 67:19:02:05, 36 SDR 27, effective August 26, 2009.

General Authority: SDCL 28-13A-4.

Law Implemented: SDCL 28-13A-4, 28-13A-6.

22:02:02:06. Claim approval process. The association shall return an application for reimbursement containing insufficient information or evidence to the county for completion and resubmission.

After receipt of the county's application, supporting documentation, and the association's recommendations, the board shall review the claim and approve, deny, or adjust the payment.

The board shall notify the county in writing if the claim is denied. The notice shall contain the reasons for the denial and shall be sent by certified mail within 10 working days after the decision is rendered.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; 22 SDR 2, effective July 17, 1995; 25 SDR 69, effective November 12, 1998; transferred from § 67:19:02:06, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-6, 28-13A-7.

Cross-Reference: Review procedure, § 22:02:01:08.

22:02:02:07. Reasons for claim denial. The board shall deny a county's claim for reimbursement for any of the following reasons:

(1) The county has not paid its CCPR annual assessment;
(2) The county has not paid its supplemental CCPR fund assessment;
(3) The county has not paid the first $20,000 for the individual for the 12-month period;
(4) The county has not provided the evidence required under § 22:02:02:05;
(5) The service was provided before January 1, 1985;
(6) The service was provided before the date of county participation;
(7) The county has not been approved as a participating county;
(8) The request for reimbursement has been delayed and the county failed to notify the department according to § 22:02:02:03;
(9) The claim is for an organ transplant for which the county has failed to meet the requirements of SDCL 28-13A-13;
(10) The county failed to follow its guidelines when determining eligibility;
(11) The county failed to pursue other third-party payment sources;
(12) The individual was not eligible for county poor relief; or
(13) The claim exceeds the payment limits established in § 22:02:02:08.

Source: 11 SDR 144, effective May 2, 1985, amended effective July 1, 1985; 19 SDR 76, effective November 23, 1992; 22 SDR 2, effective July 17, 1995; 25 SDR 69, effective November 12, 1998; transferred from § 67:19:02:07, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

22:02:02:08. Payment limits. If a county has negotiated final payment with a provider, the CCPR fund shall reimburse 90 percent of the negotiated amount, less the county's $20,000 share, if applicable.

The rate of reimbursement from the CCPR fund for a hospital expense may not exceed the limits established in SDCL 28-13-29.

If a county carries an individual over into a new 12-month period, the individual's medical expenses for the new 12-month period must exceed $20,000 before the individual's medical expenses are again eligible for reimbursement from the CCPR fund.

Source: 11 SDR 144, effective May 2, 1985, and July 1, 1985; 25 SDR 69, effective November 12, 1998; transferred from § 67:19:02:08, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-7.

22:02:02:09. Repayment to CCPR fund if county collects on claims. If a county receives a CCPR reimbursement to cover an individual's medical claims and the county subsequently collects all or part of the claims from either the individual or a third-party source, the county shall repay a percentage of the collection to the CCPR fund. The percentage of the collection to be repaid equals the percentage of the claims that the CCPR reimbursement represents.

Source: 13 SDR 134, effective March 30, 1987; transferred from § 67:19:02:09, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

22:02:02:10. County to pursue third-party payment sources. Because the county is the payer of last resort, a county must pursue the availability of a third-party payment source before accepting responsibility for a catastrophic claim. A third-party payment source is the obligation of an entity other than the county for either partial or full payment of the medical cost of injury, disease, or disability. Third-party payment sources include coverage such as Medicare, Medicaid, private health insurance, workers' compensation, supplemental security income, disability insurance, and automobile insurance.

The county must be able to document pursuit of the availability of a third-party payment source. The documentation must be maintained in the individual's record. When the claim is subsequently submitted to the CCPR program for payment, evidence of the third-party payment or rejection must accompany the claim.

Source: 22 SDR 2, effective July 17, 1995; transferred from § 67:19:02:10, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.

CHAPTER 22:02:03

ASSESSMENTS

22:02:03:01. Annual report to board. The association's annual report to the board shall contain the following information:

(1) Beginning balance of the CCPR fund;
(2) County annual assessment receipts;
(3) County supplementary assessment receipts;
(4) Disbursements;
(5) Year-end balance;
(6) Anticipated influences which could affect the new year's disbursements;
(7) A list of each participating county's annual assessment;
(8) A list of final assessments for withdrawing counties; and
(9) An estimate of the probable need for supplemental assessments in the new year.

Source: 11 SDR 144, effective May 2, 1985; transferred from § 67:19:03:01, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-8.

22:02:03:02. Annual assessments. Annual assessments shall take into consideration the unencumbered balance remaining in the CCPR fund from the previous calendar year. A county is not subject to an annual assessment until after its first year of participation.

Source: 11 SDR 144, effective May 2, 1985; transferred from § 67:19:03:02, 36 SDR 27, effective Augusts 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-9.

22:02:03:03. Supplemental assessments. The amount of the supplemental assessment shall insure the availability of funds. If the board and the association agree that a supplemental assessment is necessary, the board shall send written notice to each participating county. The notice shall contain the amount of the county's supplemental assessment. The county must pay its supplemental assessment to the association within 30 days after the county's next scheduled commission meeting following its receipt of the notice.

A withdrawing county remains liable for the payment of any supplemental assessments which the board may levy through the remainder of the calendar year.

A county which has just joined the CCPR fund and has yet to be assessed an annual assessment is liable for the payment of any supplemental assessments levied during the first year of its participation.

Source: 11 SDR 144, effective May 2, 1985; 25 SDR 69, effective November 12, 1998; transferred form § 67:19:03:03, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-10.

22:02:03:04. Final assessments. The board shall levy a final assessment against a withdrawing county which is payable to the association before March 16 of the county's first calendar year of nonparticipation.

If the fund is discontinued because of circumstances contained in SDCL 28-13A-5, the board shall levy a final assessment against the counties which were participating during the final year of the program. This final assessment is payable to the association within one year after the final assessment is levied against the remaining participating counties.

Source: 11 SDR 144, effective May 2, 1985; 13 SDR 134, effective March 30, 1987; transferred from § 67:19:03:04, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4, 28-13A-5.

22:02:03:05. Failure to pay assessment. If a county fails to pay an assessment, the association shall send a written notice to the county. The notice shall inform the county that failure to pay the assessment within the time specified in the notice will result in ineligibility and that interest on the delinquent assessment will be applied according to SDCL 4-3-14.

A county is not eligible for readmission to the fund until its arrearages are paid. Claims from the county are not reimbursable until the county's arrearages are paid.

Source: 19 SDR 76, effective November 23, 1992; transferred from § 67:19:03:05, 36 SDR 27, effective August 26, 2009.
General Authority: SDCL 28-13A-4.
Law Implemented: SDCL 28-13A-4.