South Carolina Department of Health and Human Services

SUBSTANTIAL GAINFUL ACTIVITY (SGA) QUESTIONNAIRE

Instructions: The Medicaid applicant/beneficiary, or the authorized representative, completes and signs this form when you are working and applying for Medicaid due to a disability or when a disability review is due. The completed and signed form must be mailed or given to the Medicaid eligibility worker before a disability determination can be completed. The Medicaid eligibility worker will forward the completed and signed form 3218E-ME to the Department of Disability Determination along with form 3218ME (or 3218D-ME), all signed 921 forms, available medical records, and the applicant's death certificate, if deceased.

Name of Applicant/Beneficiary:	
Social Security Number:	Telephone Number:

1. How much does the applicant/beneficiary earn each month? $_____

2. Is the applicant/beneficiary blind? ☐ Yes ☐ No

3. Does the applicant/beneficiary work in a sheltered workshop? ☐ Yes ☐ No

4. Within 6 months of beginning his/her latest job, did the applicant/beneficiary stop working, or reduce work hours or earnings, or change the type of work he/she was doing for one of the following reasons? ☐ Yes ☐ No
   - Because of his/her medical condition, or
   - Because special conditions at work related to his/her medical condition that allowed him/her to work were removed.

5. Check the boxes below that indicate the special help or extra pay that the applicant/beneficiary received in the jobs performed after he/she became disabled. (If this is a disability review, instead of application, check the boxes that indicate special help or extra pay the applicant/beneficiary received in the jobs performed since the latest disability review.)

   ☐ Special help from other workers to do job. Which job?_____
   ☐ Special equipment or work suited to his/her condition. Which job?_____
   ☐ Allowed to work at a lower standard of productivity. Which job?_____
   ☐ Worked for a relative or friend. Which job?_____
   ☐ Given a job based on past services and loyalty to employer. Which job?_____
   ☐ Worked irregular hours or took frequent rest periods. Which job?_____
   ☐ Hired through a special program for training or therapy (e.g., vocational rehabilitation, etc.) Which job?_____
   ☐ Worked fewer hours. Which job?_____
   ☐ Had fewer or easier duties. Which job?_____
   ☐ Given special transportation to and from work. Which job?_____
   ☐ Paid for extra rest periods at work or extra time off from work and other workers were not. Which job?_____
   ☐ Got higher pay than others doing same type and amount of work. Which job?_____
   ☐ Had extra help, extra supervision, or a job coach. Which job?_____
   ☐ Got special help getting ready for work. Which job?_____
   ☐ Got special benefits that other workers did not get, for example, tips, bonuses, sick or disability pay, vacation pay, meals, room or rent, transportation or use of a car or vehicle, or child care. Explain.

6. If the applicant/beneficiary is blind, complete this chart. If the applicant/beneficiary is not blind, go to # 7.

Enter in the chart the amounts of earned income the blind applicant/beneficiary uses each month to pay for work-related expenses.

Type of Expense	Monthly Amount of Expense

7. If the applicant/beneficiary is not blind, does the severity of his/her impairment require him/her to purchase or rent items and services in order to work? ☐ Yes ☐ No

If yes, complete this chart to document the types of items and services and the amount paid for them each month.

Item or Service	Monthly Amount Paid for Item or Service

Signature of Applicant/Beneficiary or Authorized Representative:	Telephone Number:	Date:
Signature of Medicaid Eligibility Worker:	Telephone Number:	Date: