TEFRA Application – Cover Letter

Dear Parent or Guardian:

This letter is to provide you with information about the South Carolina Healthy Connections Medicaid's TEFRA (Katie Beckett) program.

Why am I getting this notice?

We hope the letter will:

- Help you learn more about the program and the process to decide if a child is eligible for TEFRA.
- Give you information on how to make the application process easier.
- Tell you how to apply and get help.

What is TEFRA?

TEFRA (Katie Beckett) is a Medicaid coverage type for children who need a high level of care, like the care you may receive in a nursing home. It is for kids whose families can, and want to, provide care for their child at home. If your child had TEFRA Medicaid in another state, you must apply for it in South Carolina. You also must end the coverage in the other state.

How does a child qualify for TEFRA?

A child must meet the criteria listed below to qualify.

- The child must be 18 years old or younger.
- The child must not have income or resources more than allowed by the program. These limits are based on Supplemental Security Income (SSI) limits. Monthly income limit is 300% of SSI limit. The resource limit is $2,000.
- The child must live at home.
- The child must be able to get adequate care in their home. This care can include using services in the child's community.
- The cost of the child's care can't be more than what Medicaid would pay if the child were in a facility.
- The child must be disabled. This means the child must meet Social Security Administration standards for being considered disabled.
- The child must be deemed to need ongoing institutional care. This is called the level of care determination. This usually means nursing home care or intermediate care for the intellectually disabled (ICF-ID). It can also mean long-term care in a hospital. This requirement is NOT met because a child may need to be admitted to a hospital many times a year due to health crises or corrective procedures.

A child may have medical concerns and still not be eligible for TEFRA. If any of these rules are not met, the child can't qualify. Two of the criteria are more difficult to assess. These are the disability and the level of care determinations. They may take some time to do. Please submit all required information and documents with your application. This allows us to process your application faster.

How does a child get a disability determination?

If a child is determined disabled by the Social Security Administration and is receiving benefits, a disability determination is not needed. However, if that has not yet happened, a disability application must be filled out. We send the completed application to a third-party vendor who makes the disability determination.

You must provide your child's medical records from the physicians and healthcare providers listed on your application. Please ask your healthcare providers to give the requested documents quickly. This will help us process the application faster. Send all medical records in with your application, if you have them. If you get medical records after you send in your application, you can still send them to us. Use one of the ways listed below.

- Online: Upload it using the document upload tool. Go to apply.scdhhs.gov. Click on "Check Status/Update Information." Then click on "Submit your paperwork online."
- Fax: (888) 820-1204
- Email: 8888201204@fax.scdhhs.gov
- Mail: SCDHHS Central Mail – Attn: TEFRA, PO Box 100101, Columbia, SC 29202

If the medical records do not clearly indicate a disability, a specialist may be asked to review your child's condition. They will see if there is more information that might lead to a positive disability determination. This step makes the process longer. But, it also gives your child every chance of meeting disability status.

How do you decide the level of care?

We also review your child's condition to determine whether he or she needs institutional care. This is called level of care. This is done at the same time as the disability determination.

To meet the medical necessity criteria for institutional care, a person must have functional deficits. These are called deficits in daily living skills for their age level. This may be things such as eating, feeding themselves, bathing, getting dressed, etc.

A child must have deficits in this area that are not just due to the age-appropriate dependences of a child. The determination for a child can be hard. All children are dependent at birth for help in these areas. Therefore, the normal dependency of an infant is age appropriate. It does not mean they need institutional care. We first look at your child's abilities compared to those expected for a child of the same age. The first review is to see whether your child's functional level is so varied from the expected level that he or she would require ongoing care in a nursing home or hospital.

If your child doesn't need to live in a hospital or nursing home, we send the application to the South Carolina Department of Disabilities and Special Needs (DDSN). DDSN reviews your child's records to determine if your child has intellectual disabilities or a related condition. They also assess if your child needs ongoing care in an ICF-ID.

How long does this take?

This is a long process because we make every effort to find your child eligible. We may need to find specialists to review your child's condition if medical records do not support a disability determination. Home visits may be needed to make level of care determinations.

If you would like to provide us with more information about your child or send us a written statement about your child's condition, please send it with your application. This information may help us make disability and level of care determinations. Also, please urge your child's physicians and healthcare providers to respond quickly to requests from us for medical records.

While your child may have severe medical problems, they may still not meet TEFRA requirements. It is often the lack of need for constant institutional care that disqualifies a child. If your child is denied, it does not mean we do not think your child has serious medical problems or is seriously ill.

South Carolina is fortunate to have Family Connection of South Carolina. This organization offers support and training to parents of children with special health needs, disabilities and developmental delays. They may also be able to help you apply for TEFRA. You can reach them at (800) 578-8750. They are open Monday through Friday from 8:30 a.m. to 5 p.m. You can also visit familyconnectionsc.org.

What if my child needs autism spectrum disorder (ASD) services?

If your child needs ASD services, it is important to know Medicaid has special requirements for the services it pays for. This applies if your child has been diagnosed with ASD. It also applies if your child has been identified as being at risk for autism and still needs a diagnosis of ASD. A licensed psychologist, developmental pediatrician or a licensed psycho-educational specialist certified by the South Carolina Department of Education must certify and document through a comprehensive psychological testing report that the child meets the criteria for a diagnosis of ASD and services are medically necessary. All services must be authorized. Qualifying for ASD services does not automatically mean a child is eligible for TEFRA.

To ask about your application status, please call us. The number is (803) 741-1165. We are open Monday through Friday from 8:30 a.m. to 5 p.m.

Accessibility Options – Auxiliary Aids and Services

This notice, other forms and info are available for free in other languages. You can ask for it in other formats. This includes Braille or large print. This is a free service. Please call the Healthy Connections Member Contact Center for help. The phone number is (888) 549-0820. It is open Monday through Friday from 8 a.m. – 6 p.m. The call is free.

You can also ask for us to change your primary language to Spanish. This will help us send your notices in Spanish, if available.

Esta notificación, otros documentos e información se puede ver en otros idiomas. Se pude pedir en otras formas. Esto incluye letras mas grandes y braille. Este servicio es gratuito. Por favor llame a Healthy Connections Member Contact Center por ayuda. El número de teléfono es (888) 549-0820. Las horas de operación son 8 a.m. a 6 p.m. lunes a viernes. La llamada es gratis.

TEFRA Application - Checklist

By providing as much information as possible when you apply, SCDHHS may be able to process your application in a shorter time. Be sure to include these items when you apply. If you are not sure what to send, call our toll-free line at 1-888-549-0820 TTY 1-888-842-3620 for help.

- ☐ Application Form – DHHS Form 3290
- ☐ DHHS Form 3291ME, TEFRA In-Home Care Certification. Your child's physician must complete this form.
- ☐ DHHS 3218D-ME –Disability Report, Child Under Age 19. It is important that you fill out each blank, even to indicate not applicable (N/A).
- ☐ DHHS Form 921 – Request for Medical Records. To save time, you may also provide one extra signed copy of Form 921 in case we need to make further requests on your behalf.
- ☐ SC Department of Disabilities and Special Needs Permission to Evaluate TEFRA Applicant Form. Sign and return this form.
- ☐ Proof of ☐ Citizenship ☐ Identity (Photocopies of original documents required.)
- ☐ Photocopies of any recent medical records (within 15 months) you may have regarding your child's health. These are not mandatory but may help speed up the application process.
- ☐ Copies of recent IEP and School Psychological Evaluation for school-age children
- ☐ Proof of any income that your child receives, such as child support or Social Security
- ☐ Proof of any resources available to your child such as bank accounts, savings bonds, trust accounts, life insurance policies, etc.
- ☐ Copies of any health insurance card, front and back, showing that your child is covered. This does not affect your child's eligibility for Medicaid. We need a record of other insurance, if applicable.

Send the completed, signed application and other required forms and information by:

Mail: SCDHHS-Central Mail
PO Box 100101
Columbia, SC 29202-3101

OR

Fax: 1-888-820-1204

Why do we ask for this information?
We ask about income and asset information to let you know what coverage you qualify for and how to get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, please visit: **www.scdhhs.gov**

What happens next?
Send your complete application to the address at the end of the form. If you don't have all the information we ask for, submit your application anyway; we'll follow up with you. If you don't hear from us, visit SCDHHS.gov or call 1-888-549-0820.

Get help with this form

- Visit us online at SCDHHS.gov
- Call our Member Contact Center at 1-888-549-0820.
- In person: Visit an SCDHHS county eligibility office in your area.

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We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check eligibility for health coverage.

Your Information (Person Applying for Child)

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

2. Date of birth (mm/dd/yyyy)

3. Gender: ☐ Male ☐ Female

4. Relationship to Applicant (Child)

5. Home address

6. Apartment or suite #

7. City

8. State

9. ZIP code

10. County

11. Mailing address (if different from home address)

12. Apartment or suite #

13. City

14. State

15. ZIP code

16. County

17. Phone number

18. Other phone number

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

Email address: _____

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

Is someone helping you fill out this application?

Complete the following section if you are filling out this form on behalf of the child's parent/guardian/caregiver.

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

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

23. Organization Name (if applicable)

24. ID Number (if applicable)

Tell us about yourself (child's parents/guardians/caregiver)

Parent / Guardian 1

25. First name, Middle initial, Last name, & Suffix		26. Relationship to Child?
27. Date of birth	28. Gender	29. Social Security Number (Optional)

30. Does Parent / Guardian 1 live at the same address as the child? ☐ Yes ☐ No

Parent / Guardian 2

31. First name, Middle initial, Last name, & Suffix		32. Relationship to Child?
33. Date of birth	34. Gender	35. Social Security Number (Optional)

36. Does Parent / Guardian 2 live at the same address as the child? ☐ Yes ☐ No

37. Does anyone have Conservatorship, Guardianship or Power of Attorney for the applying child. If yes, please give us a copy of the legal or court papers and the name and phone number of the person.

☐ Conservatorship Name and phone: _____

☐ Guardianship Name and phone: _____

☐ Power of Attorney Name and phone: _____

Please tell us about the applicant (child).

38. First name, Middle initial, Last name, & Suffix

39. Child's Full Name at Birth (if different from above)	40. Mother's Full Name at Her Birth

41. Date of birth	42. Gender	43. Social Security Number*	44. If no SSN, has child applied for one? ☐ Yes ☐ No If no, see question 45

*** We need this if the child wants health coverage and has an SSN.** Providing an SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If you want help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-888-842-3620.

45. If you have not applied for a Social Security Number for the child, please list the reason:

☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN

☐ Newborn, mother NOT receiving Medicaid ☐ Newborn, mother currently receiving Medicaid

46. **Child's Race (OPTIONAL—check all that apply)**

☐ White ☐ Native Hawaiian ☐ Vietnamese ☐ Korean ☐ Black/African American

☐ Chinese ☐ Japanese ☐ Guamanian or Chamorro ☐ Asian Indian

☐ Samoan ☐ Filipino ☐ American Indian or Alaska native

☐ Other Pacific Islander ☐ Other: _____

47. **If Hispanic/Latino, ethnicity (OPTIONAL)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

48. Is the child a U.S. citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

49. Is the child a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

50. If the child isn't a U.S. citizen or U.S. national, does he/she have eligible immigration status? ☐ Yes ☐ No
    If YES, fill in the document type and ID number below.
    a. Immigration document type: _____ b. Document ID number: _____
    c. Has the parent lived in the U.S. since 1996? ☐ Yes ☐ No
    d. Date of Entry: _____
    e. Is the parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

52. Is the child a full-time student? ☐ Yes ☐ No

53. Does the child have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
    a. If YES, When did the disability begin? _____

54. Is the child blind? ☐ Yes ☐ No

55. Is the child currently in a Hospital, Nursing Home, or Residential Care Facility? ☐ Yes ☐ No
    a. If YES, Please enter the name of the Hospital, Nursing Home, or Residential Care Facility: _____
    b. Date Entered? _____

56. Does the child need to live in a medical facility or nursing home? ☐ Yes ☐ No

57. Does the child need nursing services at home? ☐ Yes ☐ No

58. Does the child need to go into a Residential Care Facility? ☐ Yes ☐ No

59. Is the child pregnant or recently pregnant? If YES, ☐ Yes ☐ No
    a. How many babies are expected? _____ b. What is the due date? _____
    c. If recently pregnant, enter the date the pregnancy ended: _____
    d. Was the child enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

60. Has the child been diagnosed with and receiving treatment for any of the following? ☐ Yes ☐ No
    - Breast Cancer
    - Cervical Cancer
    - Atypical Breast Hyperplasia
    - Precancerous Cervical Lesion (CIN 2/3)

Please tell us about the applicant's employment status

61. Does the child work? ☐ Yes ☐ No If yes, check employment type:

☐ **Employed**
If currently employed, tell us about the income below.

☐ **Not Employed**
SKIP to question 69.

☐ **Self-Employed**
SKIP to question 68.

CURRENT JOB

62. Employer name and address

63. Employer phone number

64. Wages/tips (pre-tax) $ _____

☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

65. Average hours worked each week _____ 66. Start date _____

67. In the past year, did child: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours

68. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income will child get from this self-employment this month? $ _____

OTHER INCOME THIS MONTH

69. Check all income sources that apply and complete the table below.

☐ Child Support ☐ Veteran Benefits ☐ Unemployment ☐ Net farming/fishing
☐ Pensions ☐ Net rental/royalty ☐ Social Security ☐ Workers Comp
☐ Retirement acc'ts ☐ Disability ☐ Alimony received ☐ Cash Contributions
☐ Other income

Income Source	How often received	Amount received	Comments
		$	
		$	
		$	
		$	
		$	
		$	

70. **DEDUCTIONS:** Check all that apply, give the amount, and how often the child gets it.
If the child pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that was already considered in the answer to net self-employment.

☐ Alimony paid $ _____ How often?_____ ☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $_____ How often? _____ Type: _____

71. **YEARLY INCOME: Complete only if the income changes from month to month.**

Child's total income this year

$ _____

Child's total income next year (if you think it will be different)

$ _____

Please tell us about the child's resources

72. Does the child own any property? (Include property in other states.) ☐ Yes ☐ No
If YES, check the boxes that apply and tell us about the property.

☐ Home (house, buildings and land where you live)
☐ Other House or Building (not your home)
☐ Land (not connected to current home)
☐ Vacation Home or Time Share Property

a. What is the address of the property? (List home property first)

_____

_____

_____

Owner's Name: _____

b. What is the address of the property?

_____

_____

_____

Owner's Name: _____

Is "a." above the child's home property or primary residence where he/she currently lives or where he/she wants to return to live, if living somewhere else? ☐ Yes ☐ No

73. Please check the box beside any of the items that the child owns or is buying. Tell us about it in the table below.

☐ Bank Checking Account
☐ Bank Savings Account
☐ Car, Truck, Van
☐ Certificate of Deposit
☐ Motorcycle, Boat, Camper
☐ Annuity (provide a copy)
☐ Trust Fund or Trust Account
☐ Pre-Need Burial Contract
☐ Cash on Hand
☐ Money Set Aside for Burial
☐ Cemetery Burial Space
☐ Life Insurance
☐ 401k, IRA, or Retirement Account
☐ Stocks, Bonds, Mutual Funds
☐ Farm Machinery or Business Equipment
☐ DirectExpress Debit Card for SSA, SSI or other benefits

☐ Other: _____

Owned by	Tell Us About the Asset Include the name of bank or funeral home and any account numbers or other information used to identify the asset.	Current Value or Balance
		$
		$
		$
		$

74. Does the child have private health insurance, Medicaid from another state, or Medicare?
If yes, complete the table below: ☐ Yes ☐ No

Policy Holder	List everyone covered by the insurance	Name of Insurance Company	Policy, Medicaid or Medicare ID Number

Please include a copy of the front and back of all health insurance cards

STEP 3 American Indian or Alaska Native (AI/AN)

Is the child an American Indian or Alaska Native?

☐ **If NO,** skip to Step 4.

☐ **YES. If YES,** ask for and complete SCDHHS Form 3400-Appendix B

STEP 4 Rights and Responsibilities

Read and Sign. Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.
4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community-based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, SCDHHS will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a request for such a hearing to SCDHHS in writing, by phone, in person, or I may appeal online at www.scdhhs.gov/appeals. I know that I may represent myself or be represented by someone other than myself.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

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

_____ is incarcerated.

Renewal of coverage in future years
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application.

By signing, I state that I have read and agree to the rights and responsibilities stated on this application. I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.

Signature _____ Date (mm/dd/yyyy) _____

Please print this form, then sign it on the line above before submitting.

Send in the completed application.

Mail your signed application to: **SCDHHS - Central Mail**
PO Box 100101
Columbia SC 29202-3101

OR Fax: 1-888-820-1204

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.