

any CHIP/Medicaid benefits. The funds received from Medicaid will be used by your School District to enhance Special Education services.

**How do I become eligible?**

An application is available through your local Department of Social Services office. If you are unable to determine the location of your county office, you can call 1-800-305-3064 to determine the office nearest you. Check with your local Department of Social Services for current income guidelines.

CHIP provides health insurance coverage to uninsured children whose family income is up to 200 percent of the federal poverty level (monthly income of \$3,225 for a family of four).

**How do I apply?**

You can get an application at any Social Services office, and many hospitals, schools, and other community locations.

**AREA SOCIAL SERVICES CONTACTS**

<u>County</u>	<u>Phone Number</u>
Hanson .....	995-8000 (Mitchell)
Hutchinson .....	387-4219 (Olivet)
Lincoln .....	764-5761 (Canton)
(If you are a Lincoln County resident with a mailing address of Harrisburg, Tea, or Sioux Falls, please see Minnehaha County.)	
McCook .....	425-2271 (Salem)
Minnehaha .....	367-5500 (Sioux Falls)
Miner.....	772-5770 (Howard)
Turner .....	297-3251(Parker)

**THIS INFORMATION IS PROVIDED TO YOU**

COMPLIMENTS OF

**CORNBELT EDUCATIONAL COOPERATIVE**

715 EAST 14TH STREET  
SIOUX FALLS, SOUTH DAKOTA 57104

Revised 6/2008

**2008-2009  
FREE Health Insurance  
for Children under  
Age 19**



South Dakota's

**FREE Medical Coverage  
available for children under  
age 19**

The State Children's Health Insurance Program (CHIP), expands the State Medicaid program to specifically serve eligible uninsured children. CHIP provides FREE medical coverage for children under age 19. Examples of medical payments include: physician, hospital, dental, nursing care, home health care, family planning, clinic, rehabilitation hospital, prescription drugs, and certain diagnostic services, as well as certain Special Education Services provided by school districts.

DEPARTMENT OF SOCIAL SERVICES

**WORK SHEET FOR ESTIMATING ELIGIBILITY**

- Monthly income includes the income of parents and children (under age 19) living in the home.
- Do not use earnings of children
- Do not use income of an adult unless they are a parent (Example - child not living with parent, use only child's income)
- Do not use school grants or loans (do list them on the application)

**STEP 1 MONTHLY INCOME**

\$ \_\_\_\_\_ Gross Pay/  
 Self-employment  
 (add) + \$ \_\_\_\_\_ All Other Income  
 (EQUALS) = \$ \_\_\_\_\_  TOTAL INCOME  
 (enter in Step 3)

**STEP 2 ADJUSTMENTS ALLOWED**

\$ \_\_\_\_\_ 20% of gross earnings or  
 \$90 for each employed parent who works  
 (whichever is greater)  
 (add) + \$ \_\_\_\_\_ Child care paid monthly due to  
 employment  
 (add) + \$ \_\_\_\_\_ If Child Support is  
 received, show \$50 or the actual amount if less than \$50  
 (add) + \$ \_\_\_\_\_ Child Support paid (to  
 another household, county, or child support agency)  
 (EQUALS) = \$ \_\_\_\_\_  TOTAL ADJUSTMENTS  
 (enter in Step 3)

**STEP 3**

\$ \_\_\_\_\_  TOTAL INCOME  
 (minus) - \$ \_\_\_\_\_  TOTAL ADJUSTMENTS  
 (EQUALS) = \$ \_\_\_\_\_ **ELIGIBILITY INCOME**

**PROGRAM INCOME LIMIT**

Family Size includes the parents and children (under age 19) living in the home.

FAMILY SIZE	MONTHLY INCOME LIMIT
1	\$1,214
2	\$1,634
3	\$2,054
4	\$2,474
5	\$2,894
6	\$3,314
7	\$3,734

Amount increases with each additional member.

If your eligibility income is anywhere close to the monthly income limit or, if you want an official decision, contact your county social service office.

# To Apply

**To find the phone number of the Department of Social Services in your county, call**  
**1-800-305-3064**

**What is CHIP?**

The purpose of CHIP/Medicaid is to assure the availability of quality medical care, including certain special education costs, to families who meet income eligibility. If financially eligible, children are eligible with or without private health insurance. The program is financed jointly by state and federal government and is run by the South Dakota Department of Social Services.

**Benefits to families and schools**

School districts are required to provide special education services to all eligible children. However, in an effort to maintain the highest quality of special education services to all eligible children and their families, the districts are now seeking assistance in accessing funds for certain special education costs. The benefits for eligible children and their families are two-fold. First, the costs of most medical services for your child will be paid for by CHIP/Medicaid. Second, the school districts now have available a funding source to help defray the cost of special education services provided at the local level.

**What school services are covered?**

The South Dakota Medicaid/CHIP program provides coverage of services in school districts for the following special education related services when they are provided by properly licensed or certified professionals: psychological services, physical therapy services, occupational therapy services, speech therapy services, audiological services, and nursing services. These services are provided as part of an evaluation or an individual education program (IEP/IFSP).

**What will it cost me?**

Special education services are provided to the child by signing district's authorization form, the school district will be allowed to file for CHIP/Medicaid reimbursement at no cost to you, and you will not lose

# 2008 - 2009 MEDICAID AUTHORIZATION FORM

PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR LOCAL SCHOOL DISTRICT.  
ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL.

## MEDICAID INFORMATION/DISTRICT'S AUTHORIZATION FORM

\_\_\_\_\_ (School District)

\_\_\_\_\_ (Address)

\_\_\_\_\_ (Address)

STUDENT'S MEDICAID NUMBER \_\_\_\_\_

STUDENT'S SIMS NUMBER \_\_\_\_\_

## STUDENT INFORMATION

STUDENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

## AUTHORIZATION FOR MEDICAID CLAIM

(Please initial one)

**My child is Medicaid eligible.** I give my consent for Cornbelt Educational Cooperative to submit claims to Medicaid for covered services. I authorize Medicaid to make these payments to the school district. I authorize the release of any information from the school district to Cornbelt Educational Cooperative, and by the Cornbelt Educational Cooperative to Medicaid as necessary to request payment of Medicaid benefits. I understand that I may revoke this permission at any time by notifying the Cornbelt Educational Cooperative.

**My child is not Medicaid eligible.**

**I do not wish to provide this information.**

I understand that all services will be provided to my child, without delay, without regard to Medicaid coverage status during time frame of IEP. If amount of services changes during the duration of the IEP, a new consent authorization form must be signed. Consent must be obtained each time access to public benefits is sought. Services to be provided are documented in student's IEP.

\_\_\_\_\_  
Signature of Parent or Guardian  
Or 18 year old as own Guardian

\_\_\_\_\_  
Date

**Please fold this form and tape at spots indicated. Postage is prepaid, no cost to parents.**

**Cornbelt Educational Cooperative**

715 East 14th Street  
Sioux Falls, SD 57104-5151



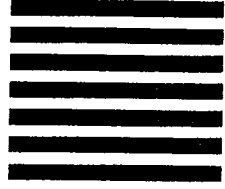
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IN THE  
UNITED STATES

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CORNBELT EDUCATIONAL COOPERATIVE  
715 E 14TH ST  
SIOUX FALLS SD 57104-9972



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