DSS-EA-300 09/20

Case #: _____ Section 1

South Dakota
Department of
Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE
609 5th Avenue
Belle Fourche, SD 57717
PHONE: 605-892-2731
FAX: 605-892-3616
WEB: dss.sd.gov

February 8, 2022

David Schied
PO Box 321
Spearfish, SD 57783

RE: Verification Checklist

Dear David ,

Attached is a verification checklist that tells you the information you must provide in order for our office to make a decision on your case.

Items marked in the "REQUIRED VERIFICATIONS" section **must** be returned by the date listed on the form.

Items marked in the "EXPENSES/OTHER VERIFICATIONS" section are not required to be returned, but may increase your benefits.

If you need help getting any of the items marked or have questions, please call me at 605-892-2731 X1500221.

Sincerely,

Kim Terrill
Economic Assistance Benefits Specialist

Additional Comments: Only the first page of your renewal application was received with a note there are no changes. I've completed the application the same as last year since there are no changes. Please review the application, make any necessary changes, complete page 10 (new questions since last year) and sign page 1 and 10. I've enclosed an envelope for you to mail back. Please call me to reschedule the telephone interview portion of the renewal.

DSS-EA-300 02/19

VERIFICATION CHECKLIST

Case # XXX52733 Section 1

Case Name: David E. Sonied **Date:** 2/8/22

Benefits Specialist: Kim **Telephone Number:** (605) 892-2731 X1500221

INTERVIEW: If an interview is required, your application will not be processed until an interview has been completed.

☑ Required for ☒ **SNAP** ☐ **TANF** call me to schedule, please

Type: ☐ In Office ☐ Telephone **Date:** / / **Time:**

☐ Not required or has already been completed

APPLICATION FOR:

☒ **SNAP** will be denied if **REQUIRED** verifications marked for SNAP are not returned by: 3/09/22

☐ Continued **SNAP** Benefits: You were approved for SNAP benefits without providing **REQUIRED** verification(s). SNAP benefits may increase, decrease or stop **without** 10-day notice.

- You **must** now provide the **required** verifications marked below by: / /
- If you do not provide the **required** verifications, your SNAP will close for: / /

☐ **TANF** will be denied if **REQUIRED** verifications marked for TANF are not returned by: / /

☒ **Medical** will be denied if **REQUIRED** verifications marked for MEDICAL are not returned by: 3/09/22

REQUIRED VERIFICATIONS: Items checked must be returned to your local DSS office.
Please contact a Benefits Specialist if you need help getting these items.

SNAP	TANF	MED	
☐	☐	☐	Social Security Number(s)/Proof of Application:
☐	☐	☐	Identification and/or Immigration Status:
☐	☐	☐	Residence verification:
☐	☐	☐	Shelter and Eating Arrangement:
☐	☐	☐	Commodity Release:
☐	☐	☐	Child Support Forms:
☐	☐	☐	Proof of Relationship:
☐	☐	☐	Work Study/Graduate Assistance:
☐	☐	☒	Bank Accounts: Recent bank statement
☐	☐	☐	Vehicle Information:
☐	☐	☐	Income Tax Forms:
☐	☐	☐	Self-Employment Ledgers:
☐	☐	☐	Wage Verification Form(s):
☐	☐	☐	Paystubs:
☐	☐	☐	Social Security/Unemployment/Veterans Benefits:
☐	☐	☐	Child Support/Alimony **Received:**
☐	☐	☐	Health Insurance Card:
☒	☐	☐	Other: Full application
☐	☐	☐	Other:

EXPENSES/OTHER VERIFICATIONS: Items checked are not required, but **may** increase benefits.

SNAP	TANF	MED		SNAP	TANF	MED	
☒	☐	☐	Authorization form signed by David	☐	☐	☐	Child Support/Alimony **Paid**
☐	☐	☐	Rent/Lot Rent	☐	☐	☐	Adult/Childcare billed in last 30 days
☐	☐	☐	Mortgage/Property Tax/Homeowner's Insurance	☐	☐	☐	Doctor' Statement
☐	☐	☐	Utility Bills	☐	☐	☐	Medical/Prescription Expenses (if disabled or over age 60)
☐	☐	☐	Other:	☐	☐	☐	Other:

SEE BACK FOR EXAMPLES

DSS-EA-301 11 20

Case #: _____ Section: 1

Economic Assistance Application RECERTIFICATION

What is Economic Assistance and How Do I Apply for Economic Assistance?

Economic Assistance programs help low income individuals, families, children, pregnant women, people with disabilities, and the elderly by providing medical, nutritional, financial, and case management services.

Step 1- Complete all questions. Sign and date the application. If you need help completing this form or bringing it to the local Social Services office, please call your local Social Services office and ask for help.
Step 2- Mail, fax, or take your application to a local Social Services office. You have the right to file this application right away by completing your name, address, and signature on this page. The date we get this page starts the time we have to decide your eligibility for the Supplemental Nutrition Assistance Program (SNAP), and/or medical programs.
Step 3- Interview. Provide proof of income and expenses. If this is not a new application, we will only need verification of any changes. An interview is required if applying for the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families.

Do You Need Interpreter Services? (Interpreter services are provided free of charge) ☑ Yes ☐ No

Please check what type of interpreter services are needed ☐ Language (list what language) legal and written
☐ Visual or Hearing Impaired ☐ Other (please describe) _____

Tell Us About You Totally and permanently Disabled Quad-amputee

Answer these questions about yourself. See letter dated 2/10/22

First Name	Middle Initial	Last Name	Social Security Number
David	One of the Peoples Sovereign	Schied	[redacted] 54 Not to be used for ID purposes

Birth Date	Primary Phone Number	Secondary Phone Number (optional)
[redacted]	605 580.5121	

Street Address	Apartment Number	County (you live in)
USE P.O. BOX ONLY [redacted]		Lawrence

City	State	Zip Code	Email Address (optional)
Spearfish	SD	57783	DESCHIED@yahoo.com

Mailing Address (if different from street address)	Do you live on an Indian Reservation?
PO Box 321 Spearfish, SD 57783	☐ Yes ☒ No
Directions to Your Home (if no street address)	**What is the best time to contact you between 8am and 5pm?**
	Anytime

What programs are you applying for? ☒ SNAP ☐ TANF ☒ Medical Assistance

Do You Need a South Dakota EBT Card? ☒ Yes ☐ No

If you choose Yes or leave blank, an EBT card will be mailed to you and your previous card will not work. If you choose No, you will not receive an EBT card.

When Will I Get Assistance?

Supplemental Nutrition Assistance Program (SNAP): You must complete the entire application, have an interview, and provide ID.

SNAP Benefits within 30 days:
You will receive SNAP benefits within 30 days if you are eligible. If you are not eligible you will receive a letter of explanation.

SNAP Benefits within 7 days: If you are eligible, you will receive benefits within 7 days if you meet one of the following:

- Households with gross monthly income less than $150 and resources of $100 or less; or
- Households with rent, mortgage, and utilities that are more than the household's gross monthly income and resources; or
- Households with a migrant or seasonal farm worker with resources (including cash, checking and savings accounts) of $100 or less, who is stopping or starting.

Medical Assistance within 45 days:
You will receive notice of your eligibility determination within 45 days after receipt of the application for most medical programs.

Temporary Assistance for Needy Families (TANF) within 30 days:
Benefits will be determined from the date the signed application is received. (An application for TANF requires another form.)

If applying for children's medical, your SNAP information and data will be used to determine the children's Medicaid eligibility unless you request me not to do so.

I certify that I will give the South Dakota Department of Social Services all information needed to review my application for TANF, SNAP, and Medical programs. This information will be true and correct to the best of my knowledge.

SIGN HERE

Signature:	Today's Date:
[signature]	2/13/22

(Signing here will start your application. You must also sign page 11 before you can receive any benefits.)

RECEIVED FEB 17 2022 DSS Belle Fourche, SD

FOR AGENCY USE ONLY

Expedited: ☐ Yes ☐ No Application: ☐ New ☒ Renewal	Receipt Date	Case Number
		0005227733

Can I Choose to Have Someone Help Me? Person helping was DSS Kim Jerrell

You can choose an authorized representative(s) to help fill out your application, give information at your interview, and speak with your Benefits Specialist for you. If you wish to have an authorized representative(s), tell us about this person by completing the following information.

Name (of Authorized Representative)	Address	Contact Number	☐ SNAP ☐ Medical
Name (of Authorized Representative)	Address	Contact Number	☐SNAP ☐Medical

DO YOU NEED INTERPRETER SERVICES?

1. **Español (Spanish)** - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-999-5612 (TTY: 711).

2. **Deutsch (German)** - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-999-5612 (TTY: 711).

3. **繁體中文 (Chinese)** - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-999-5612 (TTY：711)

4. **unD (Karen)** - ymol.ymo;= erh>uwdRAunD usdmtCd< AerRM> Ausdmtw>rRpXRvXA wvXmbl.vXmphRA eDwrHRb.ohM. vDRIAud; 1-877-999-5612 (TTY: 711).

5. **Tiếng Việt (Vietnamese)** - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-999-5612 (TTY: 711).

6. **नेपाली (Nepali)** - ध्यान □दनुहोस:् तपाइ□ले नेपाल□ बोल्नहन्छ भन तपाइ□को □निम्त भाषा सहायता सवाहरू □नःशल्क रूपमा उपलब्ध छ । फोन गनुहोसर् ्1-877-999-5612 (□ट□टवाइ: 711)

7. **Srpsko-hrvatski (Serbo-Croatian)** - OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-999-5612 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

8. **አማርኛ (Amharic)** - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-999-5612 (መስማት ለተሳናቸው: 711).

9. Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-877-999-5612 (TTY: 711).

10. **Tagalog (Tagalog – Filipino)** - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-999-5612 (TTY: 711).

11. **한국어 (Korean)** - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-999-5612 (TTY: 711)번으로 전화해 주십시오.

12. **Русский (Russian)** - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-999-5612 (телетайп: 711).

13. **Cushite Oroomiffa (Oromo)** - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-999-5612 (TTY: 711).

14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 1-877-999-5612 (TTY: 711).

15. **Français (French)** - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-999-5612 (ATS : 711).

Who Lives in your Home?

1. PLEASE LIST EVERYONE IN YOUR HOME, even if you are not requesting assistance for them.

- ► **Completion of Social Security number and citizenship is optional for those not asking for assistance.**
- ► **Completion of the country of birth, marital status, last grade completed, sex, race, and ethnicity sections are optional and will not affect your eligibility or level of benefits. If you do not select a race or ethnicity, our office must select a race or ethnicity on your behalf for required data collection purposes.**
- ► **If requesting medical assistance, and you are American Indian or Alaska Native, please complete Appendix A.**

*Marital Status Codes: N- Never Married/Single M- Married S- Separated D- Divorced W- Widow/ Widower
** Race Codes: W- White A- American Indian/Alaska Native B- Black H- Hawaiian/Pacific Islander O- Asian

Circle Program below	First Name, Middle Initial, Last Name	Relation To You (Spouse, Son/ Daughter Sibling, friend etc.)	Social Security Number	Date of Birth / Country of Birth	Sex (Circle One)	*Marital Status / Last Grade Completed (list last grade)	**Race / Ethnicity: (Hispanic or Latino? Circle Y or N)	U.S. Citizen (Circle One)	Does this person prepare and eat meals with you?
(SNAP) Medical TANF None	David Schied	Self	Not to be used for ID TTSH purposes	8/22/57 / USA	(M) F	D / masters	W / Y (N)	American National Yes No — Born in Montana	N/A
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N
SNAP Medical TANF None					M F		Y N	Yes No	Y N

If you have more people living in your home, please complete an additional page

1a. If any individual listed above, requesting assistance, is not a U.S. Citizen, complete information below:

Name & Alien #	Immigration Document Type	Document ID Number	Expiration Date	Lived in U.S. since 1996:	U.S. military status of person, spouse, or parent:
				☐Yes ☐No	☐Active Duty/Veteran ☐None
				☐Yes ☐No	☐Active Duty/Veteran ☐None

2. ☐ Yes ☒ No **Are there other names used by anyone in the home (maiden names, aliases, etc.)?**
If yes, complete below:

Household Member	Other Names Used

3. ☐ Yes ☒ No **Other than you and your spouse, are there any other parents with children living in the home? If yes, complete below:**

Parent	Children	Parent	Children

4. ☐ Yes ☒ No **Does any child on this application have a parent living outside the home?**
If yes, complete below:

Parent	Children	Parent	Children

5. ☒ Yes ☐ No **Are there other states/territories where you or anyone in the home, including children, have received food, medical, and/or cash assistance? If yes, complete below:**

City/State/Territory	Dates	County	Office Phone #	Worker Name
Michigan	9/18-2/21	Oakland	248-262-4514	
This for the STATE OF S. DAKOTA refuses "Full Faith + Credit" To this FACT				

6. ☐ Yes ☒ No **Do you or anyone in the home attend school? If yes, complete below:**

Name	Name of School	Enrollment Status	Expected Graduation Date	If this is a Boarding School, do they board?
		☐Full Time ☐Half Time ☐Less Than Half Time		☐ Yes ☐ No
		☐Full Time ☐Half Time ☐Less Than Half Time		☐ Yes ☐ No
		☐Full Time ☐Half Time ☐Less Than Half Time		☐ Yes ☐ No
		☐Full Time ☐Half Time ☐Less Than Half Time		☐ Yes ☐ No

7. ☐ Yes ☒ No **Are you or anyone in the home, currently living in an institution? If yes, complete below:**
(An institution is a facility that provides at least 50% of meals to you, such as an alcohol/drug treatment center, homeless shelter, battered women's shelter, prison, etc.)

Person in Facility	Name of Facility	Type of Facility	Date Entered facility: ___/___/___	Amount Billed for Residing in the Facility: $ _____ ☐ Room only or ☐ Room & Board

8. ☐ Yes ☒ No **Do you or anyone requesting benefits receive Tribal Commodities?**
If yes, complete below:

List Household Member (s):

9. ☐ Yes ☒ No **Are you or anyone in the home disqualified from receiving SNAP or tribal commodities due to an intentional program violation?**

List Household Member (s):

What Resources Do Members of Your Household Have?

10. ☒ Yes ☐ No **Do you or anyone in the home, including children, own or co-own any cars, trucks, boats, campers, motorcycles, trailers, or ATV's? Include all vehicles registered in your name.** If yes, complete below:

Owner / Co-owner	Year	Make (Ford, Chevy, GMC, etc.)	Model (Taurus, Blazer, etc.)	Amount Owed	Value	Vehicle use? (work, school, recreation, etc.)	Leased? (circle one)
David Schied	2008	Chevy	Uplander	$ 0	$ I am not a professional appraiser or car expert		Yes (No)
				$	$		Yes No
			This car is a liability since I must pay for	$	$ * Drivers must be hired since I am not		Yes No
				$	$		Yes No
		STATE required license, insurance + maintenance		$	$ driving myself		Yes No

11. ☐ Yes ☒ No **Other than the house you live in, do you or anyone in the home, including children, own/co-own any land, buildings, or homes?** If yes, complete below:

Owner / Co-owner	Type/ Location	Value	Amount Owed	For Sale or Rent?
		$	$	☐Yes ☐No
		$	$	☐Yes ☐No

11a. ☐ Yes ☐ No **If this property is for rent, does it produce income?**
(If yes, make sure to list the income on question #17)

12. ☒ Yes ☐ No **Do you or anyone in the home, including children, own/co-own any of the following types of resources?** If yes, complete below: *Examples: Cash, Checking, Savings, Credit Union, Direct Express or Payroll Debit Cards, Stocks, Bonds, Certificates of Deposit, Life Insurance, Trust Funds, Individual Indian Monies (IIM), Money Market Funds, Deferred Compensation Plan, Burial Funds, Contracts for Deed, IRAs, 401K, Keogh plan, PayPal, Venmo, Cryptocurrencies, or other items of value.*

Owner/Co-owner	Type of Resource	Bank/ Location	Account Number	Value/ Balance
David Schied	Checking	Huntington National Bank		$
				$
				$
				$
				$

13. ☐ Yes ☒ No **Have you or anyone in the home received lottery/gambling winnings in the past 30 days?** If yes, complete below:

Name	Date Received	Amount of Winnings	Balance as of Today's Date
		$	$
		$	$

14. ☐ Yes ☒ No **Have you or anyone in the home sold, traded, or given away anything of value within the last 3 months? (money, land, vehicles, buildings, house, etc.)** If yes, complete below:

Name	What was Transferred?	Date Transferred	Value
			$
			$

What Type of Income Do Members of Your Household Receive?

15. ☐ Yes ☒ No **Do you or anyone in the home, including children, have job income or expect to start a job? If yes, list all job income and provide proof of the last 30 days:**

Who is Working or Starting Work?	Employer Name and Address	Hours worked per month & wage per hour	Gross Income received in the last 30 days or expected to receive	Tips	How often paid?	Date of Next Check
		Hours worked: _____ Wage per hour: _____	$	$	☐ weekly ☐ biweekly ☐ monthly ☐ twice monthly ☐ Other_____	
		Hours worked: _____ Wage per hour: _____	$	$	☐ weekly ☐ biweekly ☐ monthly ☐ twice monthly ☐ Other_____	
		Hours worked: _____ Wage per hour: _____	$	$	☐ weekly ☐ biweekly ☐ monthly ☐ twice monthly ☐ Other_____	

16. ☐ Yes ☒ No **Do you or anyone in the home have income from Experience Works, WIOA, or Work Study?**

17. ☐ Yes ☒ No **Are you or anyone in the home self-employed or work odd jobs for cash?**
If yes, complete below and provide proof: (for self-employment, provide last tax return filed or monthly ledgers)

Name	Type of Work	Income per month after expenses
		$
		$

18. ☐ Yes ☒ No **Did you or anyone in the home have job income that ended in the last 60 days?**
If yes, complete below and provide proof of your final check:

Name	Employer	Last Day Worked	Final Check Date	Reason for leaving

19. ☐ Yes ☒ No **Are you or anyone in the home currently on strike?**
If yes, complete below and provide proof of your final check:

Name	Employer	When did the strike start?	Date of last check?

20. ☐ Yes ☒ No **Are you or anyone in the home a migrant or seasonal farm worker?**

21. ☒ Yes ☐ No **Are you or anyone in the home unable to work due to a health problem?**
If yes, complete below:

Name	Applied for SSA/ SSI/ VA/ Worker's Comp?	If yes, list date applied
David Schied	☒ Yes ☐ No	
	☐ Yes ☐ No	

22. ☒ Yes ☐ No **Does anyone in the home, including children, receive or expect to receive, income that is not from a job? If yes, complete below:** *Examples:* Child Support, Alimony, Social Security, SSI, SSI State Supplement, BIA /GA, Tribal TANF, Re-employment Assistance, Retirement, Worker's Compensation, Veteran's Benefits, Pensions, Annuities, Dividends, Rental Income, Tribal Lease or Per Capita Income, Prizes, Lottery Winnings, Adoption/Guardianship or Foster Care Subsidies, Money from Family/Friends, and any other sources of unearned income.

Name	Source of Income	Gross Amount this Month
David Schied	"SSA Benefits" only	$ 1164 (2022)
	* "Income" is a TAX word and	$ 899 (2021)
I do NOT pay taxes.	I am NOT a "TAXPAYER". I am	$
	a "Welfare BENEFICIARY"	$

"Under penalty of perjury"

What Expenses Does Your Household Have? ADDENDUM TO March 2021 #2 MEDICAID APPLIC.

23. ☒ Yes ☐ No **Do you or anyone in the home pay for shelter expenses?**
If yes, complete below and provide proof of the expense:

Rent	$ _____ per month	Rental Assistance/Subsidized Housing: ☒ Yes ☐ No
If renting, list the Landlord's name:		Phone
Lot Rent	$ _____ per month	
Mortgage	$ _____ per month	**Property Taxes** $ _____ per month (if not included in mortgage)
Homeowner's Insurance	$ _____ per month (if not included in Mortgage)	**Condo Fees** $ _____ per month (if not included in mortgage)

24. ☒ Yes ☐ No **Do you or anyone in the home pay for utility expenses?**
If yes, check the box(s) next to the expense(s) you are responsible to pay and provide proof:

☒ Heat--Mark what type of heating source: ☒ Electric ☐ Gas ☐ Propane ☐ Fuel Oil ☐ Wood Heat: if wood heat do you ☐Buy or ☐Cut Wood?		
☒ Air Conditioning	☐ Garbage	☐ Water
☒ Electricity	☐ Sewer	☒ Telephone Cell
☐ Cooking Fuel	☐ All of the above	

25. ☒ Yes ☐ No **Have you or anyone in the home received energy assistance (LIEAP) or tribal energy assistance within the last 12 months?**

26. ☐ Yes ☒ No **Do you or anyone in the home pay for child care or adult care in order to work, look for work, or to attend school? If yes, complete below and provide proof of the amount billed:**

Name of Person in Care	Amount Billed	How Often Billed	Provider	Receive Child Care Assistance
	$	☐weekly ☐Monthly ☐biweekly ☐Other _____		☐ Yes ☐ No
	$	☐weekly ☐Monthly ☐biweekly ☐Other _____		☐ Yes ☐ No
	$	☐weekly ☐Monthly ☐biweekly ☐Other _____		☐ Yes ☐ No
	$	☐weekly ☐Monthly ☐biweekly ☐Other _____		☐ Yes ☐ No

27. ☐ Yes ☒ No **Does anyone in the home pay court ordered child support/alimony to another household?**
If yes, complete below and provide proof of the amount paid:

Name of Person who Pays	How Much Per Month	To Whom Paid	How Often Billed
	$		☐weekly ☐Monthly ☐biweekly ☐Other _____
	$		☐weekly ☐Monthly ☐biweekly ☐Other _____

28. ☒ Yes ☐ No **Does anyone who is a person with a disability or age 60 or older, pay medical costs?**
If yes, complete below and provide proof of the medical expense: Include doctor & hospital bills, prescription drugs, dental, eyeglasses, transportation, Medicare/health insurance premiums, etc.

Name	Amount per month	Name	Amount Per Month
	$		$
	$		$

*Will provide many thousands owed from 2021 that should have been paid by MEDICAID still being DENIED from 2021

29. ☐ Yes ☒ No **Does anyone in the home make payments to a payee for services provided?**
If yes, complete below:

Name	Amount per month	Name	Amount Per Month
	$		$

30. ☐ Yes ☒ No **Do you or anyone in the home receive help paying expenses? If yes, complete below:**
Include help you get from any agency, organization or person in paying your household expenses.

Which Expense was Paid	Name of Person who Pays

ADDENDUM #2 to 2021 Application

Are you Applying for Medical Assistance? **Answer questions 31-41 only if you want Medical Assistance.**

First Addendum was November 2022

31. ☐ Yes ☒ No **Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone else's tax return next year? If yes, complete below:**

Will you file jointly with a spouse/partner?	☐ Yes ☒ No	If **yes**, please list name of spouse/ partner:
Will you claim any dependents on your tax return? I will not be filing because I am a "Welfare Beneficiary" NOT a "TAXPAYER"	☐ Yes ☒ No	If **yes**, list names of dependents:
Will you be claimed as a dependent on someone's tax return?	☐ Yes ☒ No	If **yes**, list the name of the tax filer: How is the tax filer related to you?

32. ☐ Yes ☒ No **Does anyone else in the home plan to file a federal income tax return next year or will anyone be claimed as a dependent on someone else's tax return next year? If yes, complete below:** *** Reminder: Any income of children listed below should also be listed on #15***

Name:		
Will he/she file jointly with a spouse/partner?	☐ Yes ☐ No	If yes, please list name of spouse/partner:
Will he/she claim any dependents on their tax return?	☐ Yes ☐ No	If yes, list names of dependents:
Will he/she be claimed as a dependent on someone's tax return?	☐ Yes ☐ No	If yes, list the name of the tax filer: How are they related to the tax filer?

Name:		
Will he/she file jointly with a spouse/partner?	☐ Yes ☐ No	If yes, please list name of spouse/partner:
Will he/she claim any dependents on their tax return?	☐ Yes ☐ No	If yes, list names of dependents:
Will he/she be claimed as a dependent on someone's tax return?	☐ Yes ☐ No	If yes, list the name of the tax filer: How are they related to the tax filer?

Name:		
Will he/she file jointly with a spouse/partner?	☐ Yes ☐ No	If yes, please list name of spouse/partner:
Will he/she claim any dependents on their tax return?	☐ Yes ☐ No	If yes, list names of dependents:
Will he/she be claimed as a dependent on someone's tax return?	☐ Yes ☐ No	If yes, list the name of the tax filer: How are they related to the tax filer?

33. ☐ Yes ☒ No Does anyone pay for certain things that can be deducted on a federal income tax return?

Name:	☐Student Loan Interest	☐Other deduction - list type:
	Amount $	How Often?
Name:	☐Student Loan Interest	☐Other deduction - list type:
	Amount $	How Often?

34. ☐ Yes ☒ No Is anyone in the home pregnant? If yes, complete below:

Name	Expected Due Date	Number of Babies Expected

35. ☒ Yes ☐ No Does anyone requesting medical assistance have unpaid medical or dental bills for services in the last 3 months? If yes, complete below and provide proof of income for those months:

Name	Month of Medical Bill(s)
Too many to list here, Lawsuit will be filed for recovery of debt collections activities + billing back to 2021 when first application was DENIED by discriminatory practice.	

36. ☐ Yes ☒ No Has any household member requesting medical assistance dropped group health insurance within the last 3 months?

37. ☐ Yes ☒ No Are you or anyone in the home covered or eligible for coverage under the SD State Employees insurance program? If yes, who _____

38. ☐ Yes ☒ No Is anyone in the home covered by health insurance other than Medicaid/CHIP? If yes, complete below:

Person(s) Covered	Policy Holder	Name and Address of Insurance Co.	Check Type of Insurance	Group # Policy #	Start Date/ End Date
Self			☒Medicare A ☐Vision ☐Medicare B ☐Dental ☒Medicare D ☐Mental ☐Inpatient ☐Outpatient ☐Pharmacy ☐Other		

*** If anyone listed on this application is offered health coverage from a job, complete appendix B.

39. ☐ Yes ☒ No Has any Native American household member received/eligible for a service from Indian Health Services (IHS), Urban Indian Health or other tribal healthcare? If yes, who _____

40. ☐ Yes ☒ No Was any household member in state sponsored foster care at age 18? If yes, who _____ What state? _____

*Post-gangrenous condition of nasal cavity requires equipment for daily rinsing.
*No fingers for wiping my own ass → (bidet at home only) Needs help
*Needs mobility device to transfer in/out of bed and shower/tub.

41. ☑ Yes ☐ No Does anyone have conditions that cause limitations in daily activities (like bathing, dressing, personal care etc.)? If yes, who Self - David Schied - with mobility, home chores, shaving, brushing teeth & (in home + in community) (food prep, cooking, cleaning) handwriting + transfer bench to toilet, shopping, recreation, doctors, mobility device maintenance/repairs.

(Underlined) These are the sole criteria used previously to disqualify me over the phone while refusing to put this in writing and while refusing to also "show me the law" and/or written policy.

Complete for Each Household Member Applying for SNAP or TANF

42. ☐ Yes ☒ No **Are you or anyone in the home hiding or running from the law:**
- to avoid prosecution or felony prosecution
- to avoid being taken into custody, or going to jail for a felony, attempted felony
- violating parole or probation

If yes, list name(s) _____

43. ☐ Yes ☒ No **Has anyone in the home been convicted of any of the following after September 22, 1996?**
- fraudulently receiving duplicate SNAP, TANF, Medical, or Supplemental Security Income (SSI) benefits in any state
- buying or selling SNAP benefits of $500 or more; trading SNAP benefits for guns, ammunition, explosives, or drugs

If yes, list name(s) _____

44. ☐ Yes ☒ No **Has anyone in the home been convicted of a felony after February 7, 2014 and are not in compliance with the terms of their sentence or parole?**

If yes, list name(s)_____**State where convicted:** _____

Would you like to Register to Vote?

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

☐ Yes ☒ No **If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

If you do not check either box, you will be considered to have decided NOT to register to vote at this time. (Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.)

If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

Read the Following Sections Carefully

- I agree to inform the SD Department of Social Services when
  - my household's income exceeds the maximum amount for my household size; **or**
  - I or one of my household members is eligible only because of working 20 hours a week and the employment stops or hours decrease to less than 20 hours a week; **or**
  - You or one of your household members receive lottery or gambling winnings of $3,500 or more (before taxes or other deductions). Winnings must be reported within 10 days of their receipt.
- If receiving Medical Assistance, I agree to inform the SD Department of Social Services if the number of persons living with me or a pregnancy status changes, if there is a change in income, tax filing status changes, or a change in insurance.
- I understand that by applying for and accepting medical assistance, I assign any proceeds or any other third party support, for each person for whom Medical coverage was requested, to the SD Department of Social Services.
- I understand that if any child on this application has a parent living outside the home, 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 my children, I can tell Medicaid and I may not have to cooperate.
- I understand that if any of my children on this application has a parent living outside the home, I will be asked to cooperate with the agency that collects child support from an absent parent for SNAP and TANF eligibility. If I do not cooperate, I understand I will not be eligible for TANF and SNAP benefits. If I think that cooperating to collect child support will harm me or my children, I can tell my Benefits Specialist and I may not have to cooperate
- I understand I have the right to appeal if my SNAP and/or TANF application is not acted on within 30 days or my medical application is not acted on within 45 days by Economic Assistance.
- I understand I have the right to appeal within 90 days, if I disagree with any action made regarding my SNAP benefits. I also understand that I have the right to appeal within 30 days if I disagree with any decision made regarding my TANF and/or Medical Assistance application.
- Federal and state laws and regulations limit the use and disclosure of confidential or protected health information about applicants and recipients of assistance programs.
- Social Security numbers must be provided for all members applying for or receiving assistance. (Public Law 104-193 governing TANF, authorized under the Food and Nutrition Act of 2008 as amended through Public Law 110-246, and ARSD 67:46:01:12 governing Medical Assistance): Individuals applying for assistance may request help in obtaining Social Security numbers. Social Security numbers will not be shared with Federal immigration. Social Security numbers and all other information provided will be used or disclosed in order to determine eligibility and benefit level, prevent duplicate participation, verify the accuracy of information provided, verified through computer cross matches with other Federal and State agencies (Department of Labor, Social Security, Internal Revenue Service, etc.) when a discrepancy is found, assist in collection of benefit overpayments, used for program compliance and management, and apprehend persons fleeing to avoid the law, if requested.

PENALTIES: For government agents and principals who do not "faithfully perform" their Oaths & DUTIES to the Sovereign People under the Constitutions of the STATE & UNITED STATES can be 5 year and be CRIMINALLY PROSECUTED

If you do the following...	You will...
▪ Hide information or make false statements ▪ Use SNAP benefits that belong to someone else ▪ Use SNAP benefits to buy alcohol or tobacco ▪ Trade or sell SNAP benefits, South Dakota EBT cards, or groceries purchased with SNAP benefits	**Lose SNAP and/or TANF benefits for:** ▪ 12 months for the first offense ▪ 24 months for the second offense ▪ Permanently for the third offense ▪ May be referred for criminal prosecution
▪ Trade SNAP benefits for controlled substances such as drugs Conspiracy and deprivation of rights under color of law and policy are CRIME	**Lose SNAP benefits for:** ▪ 24 months for the first offense ▪ Permanently for the second offense
▪ Trade SNAP benefits for firearms, ammunition, or explosives ▪ Trade, buy, or sell SNAP benefits of $500 or more	**Lose SNAP benefits permanently** 18 U.S.C. § 241-242
▪ Give false information when applying for or receiving assistance Determining such facts are by JURY of the Sovereign People - not a Government	▪ Be fined up to $1000 or sentenced up to 12 months in county jail, or both, if convicted of a misdemeanor ▪ Be fined up to $2000 or sentenced up to 2 years in prison, or both, if convicted of a felony
▪ Give false information with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously Functionary,	▪ Lose SNAP benefits for 10 years. I have the right to prosecute my own cases of criminal victimization
▪ Give false information affecting eligibility of Medical Assistance I reserve all of my rights!	▪ Lose Medical Assistance up to a year ▪ Be fined up to $5000 or sentenced up to 5 years in prison, or both, if convicted

You can also be fined up to $250,000 or sentenced to prison up to 20 years, or both, for doing these things. You may also be charged under other Federal or State programs and could be ordered to repay the cost of that assistance. You may also be barred from receiving SNAP for an additional 18 months if court ordered. You can also be charged with perjury.

I understand that the information on this form is subject to verification by Federal, State, and local officials to determine that such information on this application is correct and complete including citizenship and alien status of the members applying for benefits. If any information is found to be incorrect, benefits may be reduced or terminated, and I will be responsible for paying the benefits back. I declare and affirm under 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 understand I may be subject to criminal prosecution for knowingly providing incorrect information. I have read and understand the legal information and understand my responsibilities and agree to fulfill them. I understand the penalties for giving false information or breaking the rules of the assistance program(s).

Signature of Applicant: Rules do not supersede constitutional guarantees, Private property (All Rights reserved)	**Date** 2/18/22
Signature of Authorized Representative:	**Date**
Signature of Interviewer:	**Date**

Appendix A –Complete if American Indian or Alaska Native and you are requesting Medical Assistance

American Indian or Alaska Native Family Member (AI/AN)

Complete this page if you or family members are American Indian or Alaska Native. Submit this with your Application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may NOT have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:
3. Certain money received may NOT be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

AI/AN PERSON 3	AI/AN PERSON 4	AI/AN PERSON 5	AI/AN PERSON 6
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:
$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____

AI/AN PERSON 7	AI/AN PERSON 8	AI/AN PERSON 9	AI/AN PERSON 10
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:
$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____

****If you have more people living in your home, please complete an additional page****

Appendix B – Health Coverage from Jobs—Complete only if requesting Medial Assistance

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
If you need help completing this section take this page to the employer who offers coverage to help answer the questions.

Employee information

First Name	Initial	Last Name	Social Security Number

Employer information

Employer Name		Employer Identification Number (EIN)
Employer Address		Employer Phone Number
City	State	Zip Code
Who Can we Contact about Employee Health Coverage at this Job?		
Phone Number (if different from above)		Email Address

1. ☐ Yes ☐ No Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

1a. If you're in a waiting or probationary period, when can you enroll in coverage? _____/_____/_____

List the name(s) of anyone else who is eligible for coverage from this job.

Name(s): _____

Tell us about the health plan offered by this employer.

2. ☐ Yes ☐ No Does the employer offer a health plan that meets the minimum value standard?

3. For the lowest-cost plan that meets the minimum value standard* <u>offered only to the employee</u> (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

3a. How much would the employee have to pay in premiums for this plan? _____

3b. How often? ☐ Weekly ☐ Every 2 Weeks ☐ Once a month ☐ Quarterly ☐ Yearly

4. What change will the employer make for the new plan year (if known)?

☐ **Employer won't offer health coverage**

☐ **Employer will start offering health coverage to employees or change the premium for the lowest cost plan available only to the employee that meets the minimum value standard.*** (Premium should reflect the discount for wellness programs.)

4a. How much will the employee have to pay in premiums for that plan? _____

4b. How often? ☐ Weekly ☐ Every 2 Weeks ☐ Once a month ☐ Quarterly ☐ Yearly

4c. Date of change (mm/dd/yyyy) _____/_____/_____

** An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).*

THE HUNTINGTON NATIONAL BANK
PO BOX 1558 EA1W37
COLUMBUS OH 43216-1558

Huntington

DAVID SCHIED
NOLAN SCHIED
PO BOX 321
SPEARFISH SD 57783-0321

Have a Question or Concern?

Stop by your nearest Huntington office or contact us at: Customer Information Privacy Not

1-800-480-BANK (2265)

www.huntington.com

Asterisk-Free Checking Account — *Account: -------2328*

Statement Activity From:
12/23/21 to 01/20/22

Beginning Balance	**$597.82**
Credits (+)	1,164.00
Debits (-)	1,635.42
Total Fees (-)	0.00
Ending Balance	**$126.40**
Average Balance	572.78
Low Balance	126.40

Deposit / Credit Activity (+) — *Account: -------2328*

Date	Description	Amount
12/30	SSA TREAS 310 XXSOC SEC 010322 XXXXX7754A SSA	1,164.00

Check Activity (-) — *Account: -------2328*

Check #	Amount	Date Paid	Check #	Amount	Date Paid
1066S	300.00	12/27	1071S	422.00	01/06
1067S	100.00	12/28	1072S	70.00	01/10
1069S*	62.46	01/05	1073S	300.00	01/07
1070S	67.00	01/10	1075S*	258.20	01/10

(S) Indicates this check was converted to a Substitute Check.
(*) Indicates the prior sequentially numbered check(s) may have 1) been voided by you 2) not yet been presented 3) appeared on a previous statement.

Other Withdrawal / Debit Activity (-)

Account: -------2328

Date	Description	Amount
01/11	AMERICAN FAMILY CHECKPAYMT 220110 1074	55.76

Asterisk-Free Checking Balance Activity

Account: -------2328

Date	Balance	Date	Balance	Date	Balance
12/22	597.82	12/30	1,361.82	01/07	577.36
12/27	297.82	01/05	1,299.36	01/10	182.16
12/28	197.82	01/06	877.36	01/11	126.40

In the Event of Errors or Questions Concerning Electronic Fund Transfers

Contacting Us About Errors and Questions

Reporting: How, When, Where and What:

- Call us or write to us as soon as you can if you think your statement or receipt is wrong or if you need more information about a transaction. You may call our toll-free number, 1-800-480-BANK (2265), or write to The Huntington National Bank, EA4W61 P.O. Box 1558, Columbus, Ohio 43216.
- We must hear from you no later than 60 days after we sent (or made available) the FIRST statement on which the problem or error appeared. Please provide the following information:
  - Your name and account number (if any).
  - A description of the error or the transfer you are unsure about, and explain as clearly as you can why you believe it is an error or why you need more information.
  - The dollar amount of the suspected error.

Our Investigation:

- **Timing:** We will determine whether an error occurred within ten (10) business days after we hear from you and will correct any error promptly.
- **Provisional (i.e.Temporary) Credits:** If we need more time, however, we may take up to 45 days to investigate your complaint or question. If we decide to do this, we will provisionally credit your Account within ten (10) business days for the amount you think is in error, so that you will have use of the money during the time it takes us to complete our investigation. If we ask you to put your complaint or question in writing and we do not receive it within ten (10) business days; we are not required to provisionally credit your Account.

Verification of Electronic Deposits If you have authorized someone to make regular electronic fund transfers of money to your account at least once every sixty days, you can call to find out whether or not the deposit has been received by us, call either 1-614-480-BANK or call toll free 1-800-480-BANK.

Balancing Your Statement - For your convenience, a balancing worksheet is available on our web site www.huntington.com under the Planning & Tools section, or at your local branch.

South Dakota Department of Social Services

Authorization to Furnish/Release Information

All adult household members should read and sign this Authorization to Furnish/Release Information form.
This form may be used to help verify information you provide to process your application.
If you need additional copies of this form, please contact your local office or download from the website.

Case Name: David Schied

To Whom it May Concern: All of my Rights to Constitutional Guarantees are RESERVED!

I give my consent for any person, agency, or institution to supply information to the Department of Social Services, about me or my household, and to allow inspection and copying of records about me or my household by any representative of the Department. – NOTE: Any representative must show proof of qualifications to include first answering my previous FOIA ("Open Records") requests for personnel decision upon DENIALS

I authorize the Department to release information to providers, state, or federal agencies.

I release any person, agency, or institution from any liability to me or my household for supplying such information. – but only so long as the information is supported by a sworn Affidavit of an accountable human being testifying to truth and accuracy

This consent is given only for use by the Department in administration of its benefit programs.

I know I have the right to challenge the accuracy of any information furnished by any person, agency, or institution.

SIGN HERE

Signature of Applicant/Recipient — Date

Signature of Spouse/Guardian — Date 2/17/22

Address

City/State/Zip

Telephone Number

Economic Assistance Helpful Reminders

PLEASE KEEP THIS SECTION FOR YOUR RECORDS!

Information for SNAP:

I keep RECORDS of all interactions with STATE and UNITED STATE governmen agents and their principals

- You **must** report to the Department of Social Services (DSS) when:
  - Your household income exceeds the maximum amount for your household size **or**
  - You or one of your household members is eligible only because of working 20 hours a week and the employment stops or hours decrease to less than 20 hours a week; **or**
  - You or one of your household members receive lottery or gambling winnings of $3,500 or more (before taxes or other deductions). Winnings must be reported within 10 days of their receipt.
- If you have received lottery or gambling winnings of $3,500 or more, you will immediately be ineligible for SNAP. You will remain ineligible until you again meet the allowable resource and income eligibility limits.
- If required, you must complete a report form in six months.
- Social Security numbers (SSN) must be provided for all household members over the age of 6 months if you want benefits for the individual. Infants 7 months or older without an SSN must provide proof that an SSN has been applied for or the infant will be ineligible for benefits until the SSN is provided or proof of application is received.
- If eligible, you are entitled to one SNAP benefit per month. If you apply after the 15th of the month, you may receive the first and second months' benefits at the same time.
- If you receive the wrong amount of benefits, you will have to pay them back.
- You cannot receive SNAP benefits and commodities in the same month, unless the commodities are distributed through the Senior Box Program.
- Children receiving SNAP or TANF benefits are automatically eligible for the National School Lunch program if it is offered at the school the child attends.
- If you are age 18-49, able to work but not working, you may only be eligible for benefits for 3 months out of a 36 month time period unless you live with a dependent child under age 18 or other exemption criteria are met.
- If you are able to work, you must register for work and cooperate with work registration requirements. Failure to cooperate will result in disqualification. Quitting a job or voluntarily reducing employment hours, without good cause, may also result in disqualification.
- All adult household members should read and sign an Authorization to Furnish/Release Information. This form is included in the application packet for the applicant and spouse to sign. If there are other adult household members, additional forms will be provided.
- Information reported to your Benefits Specialist the first of the month or later will not change benefits until the following benefit month(s).
- You can spend SNAP benefits like cash at authorized stores for food and for edible garden plants or seeds to grow food to eat. You cannot buy alcohol, tobacco, vitamins, medicine, pet food, paper products, or hot foods prepared for immediate consumption with your SNAP benefits.
- You are not allowed to pay for food purchased on credit with SNAP benefits. If you do, you may lose benefits.
- The SD EBT card, benefits, or food purchased with the SD EBT card cannot be sold or traded. It is against the law. If benefits and/or food purchased with SNAP benefits are sold or traded, it will be investigated and if found guilty, a 12 month, 24 month, or permanent disqualification for SNAP will be implemented and the amount of any misused benefits will be required to be repaid. Individuals may also be referred for criminal prosecution which could result in a fine and/or prison time.
- Once you've received your benefits, you can use them right away. We recommend you use your South Dakota EBT (SD EBT) card at least once every 30 days. If your case closes you can still use any benefits remaining in your account for up to 12 months. The card may be used anywhere in the United States where EBT is accepted.

- If your SD EBT card is lost, stolen or damaged, you must call the EBT customer service number at **1-800-604-5099** to order a replacement. A replacement card will be mailed to you within 5-7 days. Make sure DSS has your current mailing address prior to ordering a replacement EBT card.
- The SD EBT card will last for years. It is important to keep the SD EBT card in a safe and secure location. Multiple requests for replacement EBT cards may result in an investigation.
- Funds taken from the SD EBT card must be for the exact amount of the purchase. You should not be charged sales tax on purchases made with SNAP benefits.
- Your case may be subject to a Federal or State audit whether it is active or not.
- If your SNAP case closes, your household may continue to be eligible for other assistance such as TANF and/or Medical.
- Your SNAP and/or TANF benefits may be reduced or stopped if you do not cooperate with the TANF work program.
- A copy of your application is available to you either in paper or electronic format.

Information for TANF:

- You must report to DSS when your household income exceeds the maximum amount for your TANF household size.
- A social security number must be provided as a condition of eligibility. Individuals will be ineligible until the SSN is provided or proof of application is received.

Information for Medical programs:

- After approval, for **ALL** questions regarding covered medical services or billing issues – **please call 1-800-597-1603.** You may also refer to the medical recipient handbook.
- After medical approval, to change your primary care provider, you can go on-line at http://apps.sd.gov/SW96Provider/MMCPSelectionForm.aspx call your Benefits Specialist **OR** you can stop by your local DSS office to request the change. Remember, your request will not take effect until the 1st of the next month.

General Information for all programs:

- Please make sure we have your most current mailing address because mail from the Department of Social Services is **NOT** forwarded by the Post Office.
- I understand that I must inform my Benefits Specialist if I have been convicted of an Intentional Program Violation (IPV) for any benefit program, whether the conviction was in South Dakota or any other state.
- I understand that I only have to provide immigrant status for individuals asking for or receiving benefits. However, individuals are still required to answer questions and submit verification about income and resources which may affect eligibility and benefits. An individual's immigration status will be verified if he/she applies for and/or receives benefits. Verification will be obtained by USCIS (U.S. Citizenship & Immigration Services).
- I understand that I will receive a written notice explaining the benefits I will receive. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- Information you provide and information obtained by DSS through computer cross-matching with other agencies (Dept. of Labor and Regulation, Internal Revenue Services, Social Security Administration, etc.), employers, financial sources, and other third parties will be used and may be verified when discrepancies are found.
- If you wish to appeal our decision to reduce, deny, or close benefits, you may request a fair hearing by writing any office in the Department of Social Services or send your written request directly to the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre, SD 57501-2291. **For SNAP only**, you may make your request by calling any local Department of Social Services office or the office of Administrative Hearings at 1-605-773-6851.
- You may complete your application, renewal, or 6 month report form online at the following: www.dss.sd.gov/applyonline

Read the Following Sections Carefully

- **Notice of Nondiscrimination**

  As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Social Services directly or through a contractor or any other entity with which the Department of Social Services arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Social Services directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence against Women.

  The Department of Social Services:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

  If you need these services, contact your local DSS office.

  If you believe that DSS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a discrimination complaint or grievance with: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. Phone: (605) 773-3305, Fax: (605) 773-7223, DSSInfo@state.sd.us. You can file a discrimination complaint or grievance in person or by mail, fax, or email. If you need help filing a discrimination complaint or grievance, the Discrimination Coordinator, Director of DSS Division of Legal Services is available to help you.

  You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

  This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, and 28 CFR Part 35, the Omnibus Crime Control and Safe Streets Act of 1968, Title IX of the Education Amendments of 1972, Equal Treatment for Faith-based Religions at 28 CFR Part 38, the Violence Against Women Reauthorization Act of 2013, and Section 1557 of the Affordable Care Act

- **USDA Nondiscrimination Statement**

  In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

  Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

  To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.ascr.usda.gov/sites/default/files/Complain_combined_6_8_12_508_0.pdf, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

  (1) mail: U.S. Department of Agriculture,
  Office of the Assistant Secretary for Civil Rights
  1400 Independence Avenue, SW,
  Washington, D.C. 20250-9410;

  (2) fax: (202) 690-7442; or

  (3) email: program.intake@usda.gov.

  This institution is an equal opportunity provider.

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Department of
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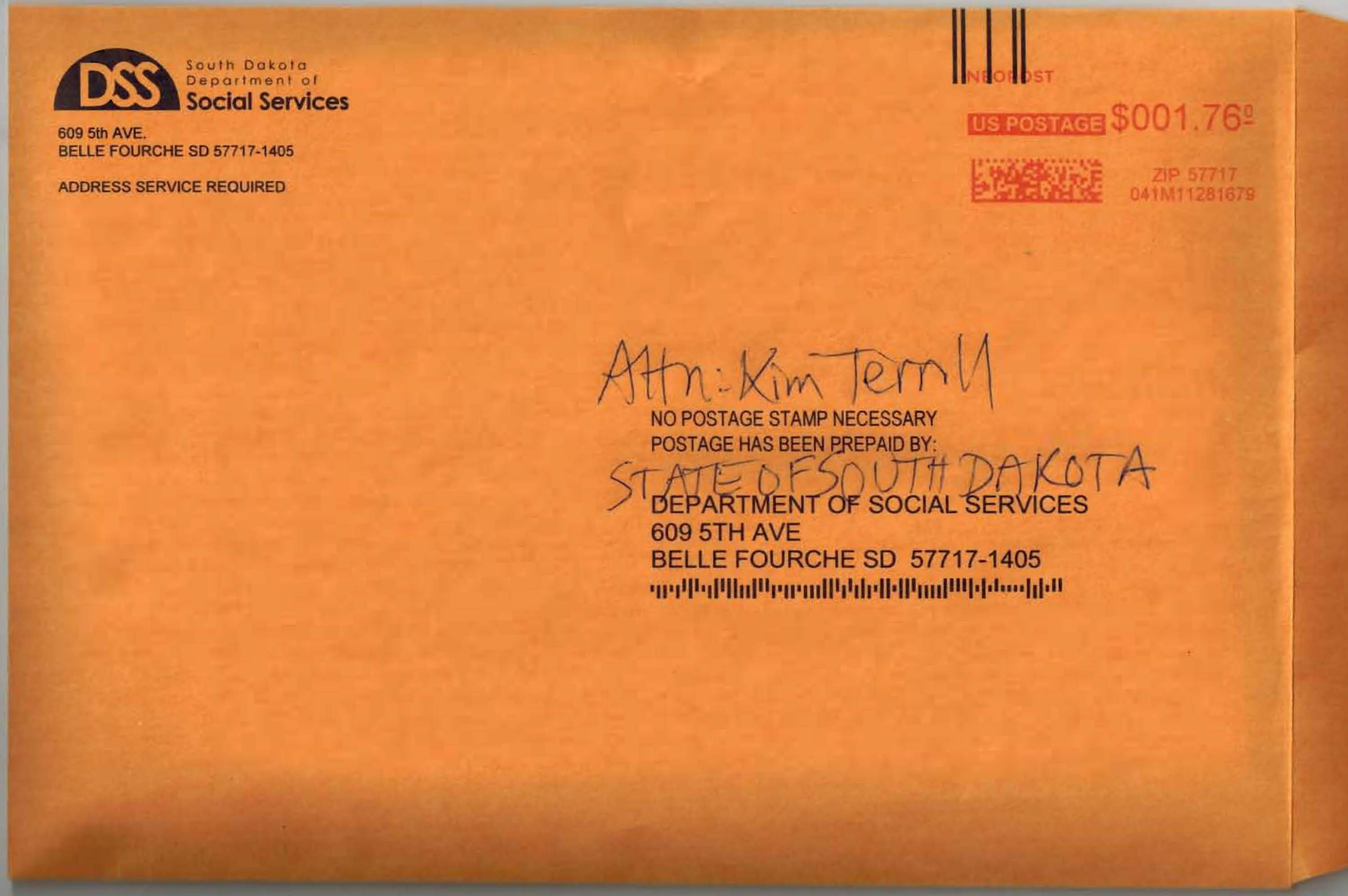

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