



Health KiCC

Health KiCC

Better Health for Kids with Chronic Conditions

Health KiCC is a program, funded through federal and state monies, that provides financial assistance for medical appointments, procedures, treatments, medications and travel reimbursement for children with certain chronic health conditions. Care coordination services are also available upon request.

Eligibility

To be eligible for **Health KiCC**, a child must:

- Be a resident of South Dakota
- Be under 21 years of age
- Have a chronic medical condition covered by **Health KiCC**
- Meet financial guidelines (up to 250% of federal poverty guidelines)

Services

Health KiCC covers 100% of eligible covered expenses

If you are eligible, the program will cover the entire cost of the coverable services after other 3rd party sources are billed. Assistance is limited to \$20,000.00 per fiscal year.

Care coordinators available based on your request/need

At your request, a care coordinator can assist you in explaining the services your child may need. This could include things like connecting to other resources; identifying the best options for your particular situation or needs; and helping to prepare your child for transitions at daycare, school and into adulthood.

Application

Complete and submit all the **Health KiCC** forms included in this mailing. Once the **Health KiCC** staff has received all of the completed forms, your child's eligibility for the program will be determined and you will be notified. If your child is eligible for the program, you will also receive instructions on how to preauthorize assistance for covered medical expenses.

If you have questions, please call 1-800-305-3064 or email: dohcshshealthkicc@state.sd.us

Health KiCC Registration Form



Child with Chronic Medical Condition Information

Child's Name _____ DOB _____ Sex (M/F) _____ SSN _____

Ethnicity: Hispanic ___ Non-Hispanic ___

Race: (Circle one) White, Black/African American, Asian, American Indian/Native Alaskan, Native Hawaiian/Pacific Islander

Parent/Guardian's Name _____ Relationship to Child _____

Mailing Address _____ City _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Email _____

Medical Information

Please return a yellow Medical Condition Verification form which has been completed and signed by your medical provider documenting your child's medical condition(s).

Insurance/Medicaid Information

Does your child have primary insurance? Yes _____ No _____

If yes, please submit a copy of both sides of each insurance card that covers the person applying for Health KiCC. This information will allow us to document whether Health KiCC is the primary or secondary payer for claims.

Does your child have Medicaid? Yes _____ No _____ Child's Medicaid # _____

Household Size: Financial assistance is based on family size and income.

____ Total number in the household that support or are supported by the household income.

Household Income

If the child applying is Medicaid eligible they are automatically income eligible for Health KiCC and no additional proof of income is necessary.

If the child applying is not Medicaid eligible, please provide proof of all gross income (amount before deductions) for all wage earners in household. **Federal income tax return form(s) is preferred.** Recent paycheck stub(s), indicating one month's income, may be used if income has changed since the most recent income tax return form(s).

Other Income – Please provide information on all income your family/household receives that is not taxable.

Type of Income	Yearly Amount Received
Child Support/Alimony	\$
SSI/Disability	\$
Other:	\$

Please call 1-800-305-3064 if you need help with your forms. Please return to Health KiCC the following information:

- * A completed Blue registration form
- * A completed Yellow Medical Condition Verification form
- * Copy of Insurance cards (front & back)
- * Proof of income **unless** Medicaid eligible (tax return or month of check stubs)

Health KiCC
600 E. Capitol
Pierre, SD 57501



Medical Condition Verification

This form can be completed by any medical providers that have documentation of the below diagnosed condition(s) and could provide, upon request, such medical documentation.

Patient's Name: _____ DOB: _____

Parent's/Guardian's Name: _____

Address: _____ Phone: _____

Chronic medical condition(s) of patient. (As per ARSD 44:06, not all chronic medical conditions are covered by Health KiCC).

Child has been diagnosed with the below:

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

Health KiCC also offers a 6 month diagnostic provision to identify if the child has a coverable condition. Once a diagnosis is made or at the end of the 6 month provision, Health KiCC will require documentation of a coverable condition for continued eligibility.

To request coverage under the 6 month provision, please list suspected ICD 9 code and diagnosis:

ICD 9 code: _____ Name of diagnosis: _____

ICD 9 code: _____ Name of diagnosis: _____

Provider Signature: _____ Phone: _____

Printed Name: _____ FAX: _____

Mail completed form to: Health KiCC
600 E. Capitol Ave.
Pierre, SD 57501

or FAX to: Health KiCC
(605) 773-5683

