



*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](mailto:dohcshshealthkicc@state.sd.us)**

**Child with Chronic Medical Condition Information**

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

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 \_\_\_\_\_

By providing my email address, I authorize the Health KiCC program to use email to communicate with me in regards to my child's health care needs and preauthorization of services.

**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.

**Please submit a copy of page one of the most recent Federal income tax 1040 form(s) to verify this.**

\_\_\_\_ Not counting parents, the number in household that are 19 years of age or older.

**Household Income:** If the child applying is Medicaid eligible he is automatically income eligible for Health KiCC and no additional proof of income is necessary.

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

**If the child applying is not Medicaid eligible, Health KiCC requires documentation of current income. Please mark the appropriate income situation:**\_\_\_\_ No jobs have changed since January of the tax year submitted above as proof of household size. **Do not submit additional income documentation as the 1040 form is reflective of current jobs.**\_\_\_\_ One or more jobs have changed. The tax form submitted does not reflect a full year of current jobs. **Please submit a recent month's pay check stubs for all wage earners in the household as the 1040 form is not reflective of current jobs.****Other Income** – Please provide information on all income your family/household receives that may not be reflected on the tax form.

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

**Insurance Information:** Does your child have primary insurance other than Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_**If yes, please submit a copy of each insurance card that covers the person applying for Health KiCC.**

**Please call 1-800-305-3064 if you need help with your forms.** Eligibility determination will occur once Health KiCC receives all the following information:

- A completed Registration form
- Most recent 1040 tax form unless Medicaid eligible
- A month's worth of check stubs only if jobs changed
- A completed Medical Condition Verification form (completed by provider)
- Copy of Insurance cards if applicable

Health KiCC

600 E. Capitol

Pierre, SD 57501

FAX: 1.866.579.8246

Email: dohcshshealthkicc@state.sd.us



**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 10 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 diagnosis and ICD 10 code:*

*Suspected diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_*

*Suspected diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_*

Provider Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Printed Name: \_\_\_\_\_ FAX: \_\_\_\_\_

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

or FAX to: Health KiCC  
(866) 579-8246

