

South Dakota Department of Health Family Card

HOUSEHOLD INFORMATION

ID Name Income Update # In Household Unborn Child Counted

Other Agency Program Participation: TANF Food Stamps Medicaid/CHIP FDIPIR

INCOME

Employment

Name of Household Member: _____ Employer/Business: _____ Self-Employed Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 2X/Month <input type="checkbox"/> Yearly <input type="checkbox"/>
Name of Household Member: _____ Employer/Business: _____ Self-Employed Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 2X/Month <input type="checkbox"/> Yearly <input type="checkbox"/>
Name of Household Member: _____ Employer/Business: _____ Self-Employed Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 2X/Month <input type="checkbox"/> Yearly <input type="checkbox"/>
Name of Household Member: _____ Employer/Business: _____ Self-Employed Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 2X/Month <input type="checkbox"/> Yearly <input type="checkbox"/>
Name of Household Member: _____ Employer/Business: _____ Self-Employed Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 2X/Month <input type="checkbox"/> Yearly <input type="checkbox"/>

Other Income

Type of Income	Amount	Frequency	Person Getting This Income
BIA General Assistance	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Child Support / Alimony	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Interest	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Military	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Pension	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Social Security	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Suppl Security Income	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Capital Gains	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Lump Sum Payment	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
TANF	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>
Other	<input type="text"/>	Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr <input type="checkbox"/> Bi-Wk <input type="checkbox"/> 2X/Mo <input type="checkbox"/>	<input type="text"/>

For Office Use Only

Total Income: Proof Of Income:

Family Address

Address	City	State	Zip Code	Phone Number	Extension
<input type="text"/>					

Family Members

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

ID: _____	Name: _____	Suffix: _____	Maiden Name: _____	DOB: _____
SSN: _____	Sex: __	Marital Status: _____	Race: _____	Ethnicity: _____
Email: _____	Health Coverage: _____ MD #: _____			

Marital Status: D = Divorced LT = Living Together M = Married SP = Separated SI = Single W = Widowed	Race: W = White B = Black/African American NA = American Indian/Native Alaskan A = Asian PI = Native Hawaiian/Pacific Islander	Ethnicity: H = Hispanic NH = Non-Hispanic	Health Care Coverage: IN = Insurance MD = Medicaid CH = CHIP IH = HIS ML = Military MC = Medicare VA = VA NC = No Coverage
---	--	--	---