South Carolina Department of Health and Human Services

MEDICAL SUPPORT REFERRAL FOR LOW INCOME FAMILIES (LIF) CASES

Must be completed in ink — Agency Use Only

Family Number:	Medicaid ID Number:	County:	Date Referred to Child Support Enforcement:

If Good Cause has been determined, attach the verification and documentation to the DHHS Form 2700 and file in the case record.

CUSTODIAL PARENT (CP) INFORMATION

Name: *(Last, First, MI)*	Social Security No:	Sex: ☐ M ☐ F	Date of Birth: / /	Relationship to Children:	Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other:

Street Address: City: State: Zip Code:

Mailing Address: City: State: Zip Code:

Name/Address of Your Employer: | Shift: | Home Telephone No: ( ) | Work Telephone No: ( )

Do you have an attorney actively engaged in child support action? ☐ Yes ☐ No *(If Yes, attach release.)*

Current Marital Status: ☐ Married ☐ Divorced ☐ Common Law ☐ Other _____ Spouse's Name: _____

Place of Marriage: _____ Marriage Date: / / Divorce Date: / /

LIST NAMES OF CHILDREN TO BE SUPPORTED BY ABSENT PARENT

Child's Name:	Child's Sex:	Child's Medicaid ID No:	Child's SS Number:	Child's Birth Date:	Child's Birthplace:	Paternity Legally Verified?
	☐ M ☐ F			/ /		☐ Yes ☐ No
	☐ M ☐ F			/ /		☐ Yes ☐ No
	☐ M ☐ F			/ /		☐ Yes ☐ No
	☐ M ☐ F			/ /		☐ Yes ☐ No

Relationship of children's parents at time of birth: ☐ Married ☐ Divorced ☐ Common Law ☐ Other _____

If Married, Date of Marriage: / /

Place of Marriage *(City/State)*:

ABSENT PARENT INFORMATION *(Information is crucial to locate activity. Fill out completely and accurately.)*

Name *(Last, First, MI)* | Alias/Nickname: | Social Security No:

Mailing Address: City: State: Zip Code: | Is address current? ☐ Yes ☐ No | If No, date last lived there: / /

Street Address: City: State: Zip Code: | Is address current? ☐ Yes ☐ No | If No, date last lived there: / /

Previous Address: City: State: Zip Code: | Home Telephone No: ( ) | Work Telephone No: ( )

Date of Birth: / / | Birthplace: | Driver's License No: | Expiration Date: / / | Current Marital Status:

Sex: ☐ M ☐ F | Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: | Weight: lbs | Height: ft in | Hair Color: | Eye Color: | Identifying Marks:

Last Known Employer's Address/Telephone No: ( ) | Date Last Worked: / / | Monthly Salary: $

Father's Name & Address/Telephone No: ( )

Mother's Name & Address/Telephone No: ( )

Name/Address of Last School Attended:

Police Record? ☐ Yes ☐ No	Date of Arrest:: / /	Place: *(City/State)*	Offense:	Location of Incarceration:	Release Date: / /

Usual Occupation:	Served in Armed Forces: ☐ Yes ☐ No	Branch:	Entry Date: / /	Discharge Date: / /

SUPPORT INFORMATION

Do you receive child support? ☐ Yes ☐ No

Are payments made to you or through the courts ? To me *or* Through the courts *(Circle the correct answer.)*

If other, explain:

Child's Name	Amount	Voluntary?	Court-ordered?	How often paid?	Date last payment was received?	Amount overdue?
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$

If Court-ordered, Docket Number: _____

Name/Address of Court:

☐ If any answer above is unknown, the information is truly not known and I have no way of finding out the information.

☐ I give the above information as truthful and correct to the best of my knowledge for the purpose of receiving Medicaid and will be used in court against the absent parent.

Signature of Custodial Parent/Applicant	Date: / /	Signature of Medicaid Eligibility Worker:	Date: / /

Directions to Home and Absent Parent / Remarks:

I understand that I am protected by Title VI of the Civil Rights Act, and I will make written complaints to the State Director, South Carolina Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-1520, within 180 days if at any time I am denied services or otherwise discriminated against because of race, color, creed, sex, religion or national origin.

INSTRUCTIONS

Applicants:

1. Complete each field on the form.
2. Return the form to your Medicaid eligibility worker.

Medicaid Eligibility Worker:

1. Review form to ensure each field is completed.
2. Send or deliver the completed form to the South Carolina Department of Social Services to one of the addresses listed below.

By courier service to:
South Carolina Department of Social Services
Child Support Enforcement Division
3150 Harden Street
Columbia, South Carolina 29202

By mail to:
South Carolina Department of Social Services
Child Support Enforcement Division
Post Office Box 1469
Columbia, South Carolina 29202-1469

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS 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 grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are 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 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html