SOUTH DAKOTA
state employee
benefits program
learn. act. thrive.

PMB 0141-1
Bureau of Human Resources
Benefits Program
500 East Capitol Avenue
Pierre, SD 57501-5070
Phone: 605.773.3148 or 877.573.7347, option 2
Fax: 605.773.6840

(BHR USE ONLY) Remarks: _____

_____

PS Initials: _____ **Agency :** _____
Emp #_____

INCAPACITATED DEPENDENT CHILD CERTIFICATION
TO BE COMPLETED BY EMPLOYEE

1. Group Name	1.a. Employee Phone Numbers Home: Work:
2. Employee Name (last, first, middle initial)	2.a. Social Security #
3. Spouse Name (last, first, middle initial)	3.a. Social Security #
4. Employee Address (number, street, city, state, and zip code)	

5. Full Name of Child	5.a. Child's Date of Birth Month Day Year	5.b. Child's Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced
5.c. Child's Relationship to Employee	5.d. Child's Relationship to Employee's Spouse	5.e. Child's Gender ❑ Female ❑ Male

6. Are you required to provide coverage by a legal qualified medical child support order (QMCSO)? ❑ Yes ❑ No
If "No," please explain

_____

_____

7. Do you provide at least 50% of the child's total support?
NOTE: Support includes food, shelter, clothing, medical and dental care, education, and the like ❑ Yes ❑ No
If "No," please explain

_____

_____

8. In reference to question number 7, is the child confined to an institution or attending school? ❑Yes ❑ No
If "Yes," please list the school

_____

_____

9. Is the child incapacitated due to a mental or physical impairment? ❑ Yes ❑ No
NOTE: A separate affidavit of incapacitated child form may need to be completed.

10. Is the dependent child employed for wages? ❑ Yes ❑ No

If “Yes,” give name of employer and approximate number of hours worked per week.

Employer Name:_____

Number of hours worked:_____

11. Is the dependent child receiving Medicare benefits? ❑ Yes ❑ No

If "Yes," include copy of Medicare Card or SSI Benefits with application and benefits effective date.

_____

_____

12. Is the dependent child receiving Medicaid benefits? ❑ Yes ❑ No

If "Yes," include copy of Medicaid Card with application.

_____

_____

I further understand:

It is the responsibility of the applicant to notify the South Dakota State Employee Benefits Program of any change in the status of the dependent’s incapacity. The South Dakota State Employee Benefits Program shall have the right to require recertification of eligibility for continuation of coverage as an incapacitated dependent.

If I have additional questions or need assistance completing this form, I will contact the South Dakota State Employee Benefits Program at 605.773.3148 or 877.573.7347, option 2.

I certify the above statements are true and complete to the best of my knowledge and belief.

_____ _____

Employee Signature Date

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Emp #_____

INCAPACITATED DEPENDENT ATTENDING PHYSICIAN CERTIFICATION
TO BE COMPLETED BY PHYSICIAN

Name of Patient:_____Date of Birth ____/____/___
Mo. Day Year

Date of First Examination ___/___/___ Date of Last Examination ____/___/___Frequency of Visits:_____
Mo. Day Year Mo. Day Year

Diagnosis/Disability (Include ICD9 Code-Required)

_____

_____

Clinical Information:
(Medical summary documenting all items listed can be attached to form in lieu of completing this section)

Onset (specify date) _____/_____/_____
Mo. Day Year

Pertinent Clinical Findings and Course (including recent lab data)

_____

_____

_____

Other Medical Problems

_____

_____

Current Medications

_____

_____

Treatment Plan (include expected duration)

_____

_____

_____

If the disability is psychiatric, please complete this section also (or address these items in your narrative report)

Complete DSMTV diagnosis **required** with descriptors, codes, and severity specifiers:	Is the dependent financially competent? ❑ Yes ❑ No Is the dependent fully compliant with treatment? ❑ Yes ❑ No
Axis I	If non compliant, how not? If not, might the prognosis below be different if he/she were compliant? ❑ Yes ❑ No
Axis II	Has the dependent been hospitalized for a psychiatric condition? ❑ Yes ❑ No
Axis III	Dates and facility:
Axis IV Axis V GAF, current: GAF, highest, past yr.	What is the nature and degree of the dependent's impairment in his/her capacities for: daily activities? task performance? social interaction?

If disability involves developmental delay or intellectual deterioration, has IQ testing been performed?
❑ Yes ❑ No Results _____ Date performed _____

If not, what intellectual functions can be performed, (e.g. math, reading, comprehension, memory skills)

_____

_____

Is the dependent: Ambulatory ❑ Yes ❑ No	Non Ambulatory ❑ Yes ❑ No
Bed Confined ❑ Yes ❑ No	Wheelchair Confined ❑ Yes ❑ No
House Confined ❑ Yes ❑ No	Hospital/Institution Confined ❑ Yes ❑ No

Facility Name_____

Is the dependent independently capable of supporting himself/herself through gainful employment?
❑ Yes ❑ No

Prognosis of Totally Disabling Condition:

____Permanent and Total _____Permanent and Partial (%)

____Temporarily Disabled with Expected Return to Partial Function (%)Return Date _____/_____/_____
Mo. Day Year

____Temporarily Disabled with Expected Return to Full Function (%)Return Date _____/_____/_____
Mo. Day Year

I certify that the above statements are relative to the disabled dependent named are true and complete to the best of my knowledge and belief.

_____ _____/_____/_____
Signature Mo. Day Year

Physician Name_____

Physician Specialty_____

PhysicianAddress_____

_____

_____

License Number_____

Internal Use only

Date Received_____ Date to be reviewed by_____

Medical Review was completed:

By_____Date_____