Department of Social Services
Division of Economic Assistance
811 E. 10th St
Sioux Falls SD 57103
Phone: (605)367-5500 ext 142
Fax: (605) 367-5473

FOLLOW-UP INFORMATION TO APPLICATION/REVIEW FOR MEDICAL COVERAGE

Name:	Case Number:
Address:	Benefits Specialist:
	Date: July 12, 2007

Dear _____:

☐ **A.** Your Medical Assistance application has been approved. You will receive a separate notice listing the individual(s) approved for medical coverage, if you have not already received one.

☐ **B.** Your Medical Assistance case has been reviewed by your benefit specialist and your Medical Coverage continues for the following people:

☐ **C.** Complete and return the Primary Care Provider (PCP) Selection form within 10 days or a PCP will be selected for you.

☐ **D.** Provide current insurance cards for:

☐ **E.** Other:

Please read through the enclosed informational materials.

- Medical Assistance Recipient Handbook—tells what is covered and how to use the medical card.
- Rights and Responsibilities for the Medical Program.
- Brochure "Looks Can Be Deceiving".
- DSS Notice of Privacy Practices.

Please contact this office if you have any questions.

NOTE: The income reported on your Application or Review may be within the limits for the program marked below. The "x" does not mean we have determined you are eligible, because assets must also be considered. A separate application would have to be filed at the local Social Services Office if you are interested in applying for any other assistance. Please call if you would like more information.

☐ Medical coverage for a parent or adult relative under Low Income Family Program.

☐ Food Stamps

PLEASE KEEP FOR YOUR RECORDS