



**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**

<b>(BHR USE ONLY) Remarks:</b> _____	
_____	
<b>PS Initials:</b> _____	<b>Agency :</b> _____
<b>Emp #</b> _____	

<b>INCAPACITATED DEPENDENT CHILD CERTIFICATION TO BE COMPLETED BY EMPLOYEE</b>		
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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
5.c. Child's Relationship to Employee	5.d. Child's Relationship to Employee's Spouse	5.e. Child's Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
6. Are you required to provide coverage by a legal qualified medical child support order (QMCSO)? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain _____ _____		
8. In reference to question number 7, is the child confined to an institution or attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list the school _____ _____		
9. Is the child incapacitated due to a mental or physical impairment? <input type="checkbox"/> Yes <input type="checkbox"/> 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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<b>Emp #</b> _____	

**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)

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**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)

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Other Medical Problems

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Current Medications

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Treatment Plan (include expected duration)

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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\_\_\_\_\_