



Greetings from the South Carolina Health Coverage Tax Credit (SCHCTC) Program! This program is designed to pay 72.5% of eligible health insurance premiums for qualified individuals. You could qualify if you meet the following criteria.

**Three ways to be eligible**

- If you receive these benefits, you could be eligible:
1. **Trade Adjustment Assistance (TAA) benefits:** you receive unemployment insurance benefits and are eligible for Trade Readjustment Assistance (TRA), or you receive TRA benefits
  2. **Alternative or Readjustment Trade Adjustment Assistance (ATAA or RTAA)**
  3. **Pension Benefit Guaranty Corporation (PBGC)**

**Qualifying Health Insurance**

- In addition, you must also be enrolled in qualified health coverage. Qualified health insurance for the SCHCTC Program includes:
- **COBRA** coverage through a former employer;
  - The **State Qualifying Plan** through:
    - BlueCross BlueShield of South Carolina, 1-800-868-2500, ext 46401
    - When calling, you should ask for the “HCTC Qualifying Plan”
  - **Individual (non-group) insurance** provided you were enrolled in that insurance at least 30 days prior to your last day of work.

**Eligible costs**

SCHCTC can pay 72.5% of medical premiums only. Other separate charges, such as dental or vision, are not covered by SCHCTC and will be included in your total. Additionally, COBRA participants are charged a 2% administrative fee by the COBRA provider which will not be covered by SCHCTC.

**Application process**

Return the completed application and required documents to the SCHCTC office. If you are eligible for SCHCTC, you will receive an “award letter” detailing your payment instructions. SCHCTC collects your portion of the premium and then forwards a full payment to the insurance company. You will be notified by mail once SCHCTC has made your payment. **You should continue to pay your insurance premiums directly to your insurance company until you receive your award letter from SCHCTC.**

**Gap-filler**

SCHCTC is a **temporary** “gap-filler” program that can assist with **up to three monthly premiums**. SCHCTC is designed to assist you only during the time that you are becoming enrolled in the Federal HCTC Program. You should apply with the Federal HCTC program **immediately** since it can take up to three months to become enrolled with them. Once you become enrolled with the Federal HCTC, you should notify SCHCTC. Call 1-866-628-4282 to request a Program Kit from the Federal HCTC.

**South Carolina Health Coverage Tax Credit**

SCHCTC  
 PO Box 1316  
 Salisbury MD 21802-1316

Phone: 1-888-341-7125  
 Fax: 1-877-341-7126

To apply online or for general information: [www.schctc.info](http://www.schctc.info)

## Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

## Eligibility for SCHCTC

### Check one to indicate your eligibility type:

- I receive TRA benefits, or would, but I am still drawing my Unemployment Insurance benefits  
Trade Certified Company: \_\_\_\_\_ Location: \_\_\_\_\_
- I receive ATAA or RTAA benefits  
Trade Certified Company: \_\_\_\_\_ Location: \_\_\_\_\_
- I receive PBGC benefits  
Date of first pension payment (mm/dd/yyyy): \_\_\_\_\_

## Health Plan Information

Health Insurance Company: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Monthly Premium Amount: \$ \_\_\_\_\_ Next Premium Due Date: \_\_\_\_\_

### Check one to indicate the type of health insurance that you have:

- I am enrolled in COBRA **and** I am responsible for more than 50% of the premium cost.  
My COBRA Administrator is: \_\_\_\_\_
- I am enrolled in the State Qualifying Health Plan.
- I am enrolled in an individual (non-group) insurance plan **and** my effective date of coverage was at least 30 days prior to my last day of work. My last day of work was: \_\_\_\_\_. My first date of coverage was: \_\_\_\_\_.
- I am enrolled in insurance through my spouse's employer.

## Family Member Information

**List all family members that are on your health insurance plan:**

Qualifying Family Member #1

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Relationship (Circle One): Spouse / Child / Other: \_\_\_\_\_

I claim this person or file jointly with this person on my tax return (Circle One): Yes / No

Qualifying Family Member #2

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Relationship (Circle One): Spouse / Child / Other: \_\_\_\_\_

I claim this person or file jointly with this person on my tax return (Circle One): Yes / No

Qualifying Family Member #3

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Relationship (Circle One): Spouse / Child / Other: \_\_\_\_\_

I claim this person or file jointly with this person on my tax return (Circle One): Yes / No

## Additional Information

**Check yes or no for each question listed below:**

**YES NO**

- Are you, or any family member listed on this application, in prison?
- Are you, or any family member listed on this application, **entitled** to health coverage through TRICARE/CHAMPUS (U.S. military health benefits)?
- Are you, or any family member listed on this application, **entitled** to Medicare Part A?
- Are you, or any family member listed on this application, **enrolled** in Medicare Part B?
- Are you, or any family member listed on this application, **enrolled** in the Federal Employees Health Benefits Program (FEHBP)?
- Are you, or any family member listed on this application, **enrolled** in Medicaid?
- Is any family member listed on this application, **enrolled** in the State Children's Health Program?
- Do you, or does any member of your family listed on this application, have additional health insurance?

If you answered "yes" to any of the above, please list which family member(s) \_\_\_\_\_

## Document Checklist

The following information should be returned to SCHCTC to determine your eligibility:

**For all applicants:**

- Completed Application
- Age verification (photocopy of Birth Certificate OR Driver's License) for each individual on the insurance, including the applicant
- Photocopy of Health Insurance Bill

**For applicants with COBRA coverage:**

- Photocopy of your COBRA election letter or enrollment form that you signed and dated to elect to continue your coverage

**For applicants with individual insurance in effect at least thirty days prior to the last day of work:**

- A statement from your former employer or unemployment agency indicating your last day of work
- A statement from your insurance provider indicating that your plan is a non-group policy and stating your effective date of coverage

**For PBGC applicants:**

- Verification that you receive the PBGC benefit (current check stub or statement from PBGC)

**Additional Information may be requested if necessary**

## Signature

Under penalties of perjury, I declare that the information furnished on this form with regard to myself and any qualified family member(s), and any attachments to it, are true, correct, and complete. I understand that a knowing and willing false statement on this form can result in a disqualification from participating in the South Carolina HCTC Gap Payment Program. By signing this statement, I agree to allow the State of South Carolina HCTC Program Operator to share my eligibility status with my health plan administrator. I also agree to allow the State of South Carolina Program Operator to share my application and supporting documents with the Federal HCTC Program Operator.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**IN ADDITION TO FILING THIS APPLICATION WITH SCHCTC, PLEASE INITIATE YOUR SEPARATE REGISTRATION WITH THE FEDERAL HCTC PROGRAM BY CALLING 1-866-628-4282.**