INFORMATION NEEDED FOR COMPLETE APPLICATION FOR ASSISTANCE

APPOINTMENT FOR:

COUNTY:

In order for the county to be able to process your application as quickly as possible, it is essential for you to review this entire packet and fill out the information as completely as possible for your appointment on:

DAY: DATE: TIME:

If you have any questions, please call Jennifer Guthmiller, McPherson County Welfare Administrator at (605) 439-3314. It is important that you keep the above referenced appointment. If you are unable to keep the appointment, please call and cancel. When you return for your appointment you will need to provide the following documentation, if applicable to your situation.

1. Letter from your mortgage company stating loan balance and monthly payment, which payment may include the principal, interest, taxes and insurance (PITI).
2. Tax assessment of property.
3. Title/bill of sale and loan payoff on all recreational vehicles, cars, boats, motorcycles, or any other motor vehicles and the montly payments.
4. Cash on hand and in bank accounts, CDs, trusts, annuities, investments, and capitol gains.
5. Equity value of business real estate, equipment, and inventory.
6. A copy of last year's complete tax form.
7. Record of gross income for the past 60 days, including V.A. pension, child support, social security, disability, and worker's compensation. If self-employed, most recent quarterly tax form and last year's income tax forms.
8. Social security cards for all members of the household.
9. Record of income earned through interest, dividends, rents, royalties and investment gains.
10. Information concerning school grants and stipends (excluding tuition and books).
11. Receipts relating to monthly expenses, including child care, child support, alimony, utilities, rent or mortgage payments, rent receipts, and/or lease agreements.

(continued)

INFORMATION NEEDED FOR COMPLETE
APPLICATION FOR ASSISTANCE
PAGE 2

12. Payments relating to health, life and auto insurance.
13. Proof of the availability of health insurance from employer(s), if offered, and the amount of premium that is the household's responsibility.
14. Payments to medical providers.
15. Payment for medications.
16. Medical records and attending physician statements pertaining to the hospital bill for which you are seeking assistance. If outpatient procedure, need CPT coding from doctor.
17. Signed release of information.

APPLICATION FOR MEDICAL ASSISTANCE

County of Residence:_____

Applicant's Full Name:_____

AKA (Also Known As): _____

Maiden Name (if applicable):_____

Address:_____

Telephone Number: Home:_____ Work:_____

SSN:_____ DOB:_____

Are there any other Social Security numbers that you have used in the past (circle): YES NO
If yes, please list those numbers: _____

MARITAL STATUS (circle one): Married Separated Divorced Single Widowed

If formerly married, list name of former spouse(s), date of marriage, divorce, death or separation:

CITIZEN INFORMATION

Are you a citizen of the United States (circle): YES NO
If not, what is your citizen status: _____

SPOUSE INFORMATION
PLEASE COMPLETE IF NOT LEGALLY DIVORCED

Spouse's Full Name:_____

AKA (Also Known As): _____

Maiden Name (if applicable):_____

Address:_____

Telephone Number: Home:_____ Work:_____

SSN:_____ DOB:_____

Are there any other Social Security numbers that your spouse has used in the past:
YES _____ NO_____ If yes, please list those numbers: _____

SIGNIFICANT OTHER TO WHOM NOT LEGALLY MARRIED

Full Name:_____

AKA (Also Known As): _____

SSN:_____ DOB:_____

PLEASE LIST ALL OTHER HOUSEHOLD MEMBERS FOR WHOM YOU ARE RESPONSIBLE

Full Name:_____

SSN:_____ DOB:_____

Full Name:_____

SSN:_____ DOB:_____

Full Name:_____

SSN:_____ DOB:_____

Full Name:_____

SSN:_____ DOB:_____

Does anyone besides yourself claim you as a dependent on their income tax:_____

HISTORY OF RESIDENCE

How long have you lived in this county:_____

Previous address:_____ County:_____

Did you/spouse move to this county for purposes of medical care (circle): YES NO

If yes, please explain: _____

MEDICAL INFORMATION

Was this illness an emergency (circle): YES NO Date of emergency: _____

If yes, please explain: _____

If no, please list date of scheduled service: _____

Has your doctor authorized you to return to work (circle): YES NO

If no, when is your anticipated date of return:_____

Are you a Native American (circle): YES NO

If you are a Native American, are you an enrolled tribal member (circle): YES NO

If yes, what tribe:_____

Are you a Veteran (circle): YES NO

If you are a Veteran, are you enrolled with the V.A. Hospital (circle): YES NO

Have you tried or have you been making reasonable payments to the hospital:

YES _____ NO_____ If yes, what is the amount due on the hospital bill:_____

What is the amount of your monthly payment:_____

How much have you paid on this bill: _____

LEGAL CLAIM INFORMATION

Are you or your spouse currently involved in a law suit (circle): YES NO

If yes, briefly explain: _____

Please provide the name, address and telephone number of the attorney handling your lawsuit:

Have you or your spouse ever been involved in a law suit (circle): YES NO

If yes, briefly explain: _____

Please provide the name, address and telephone number of the attorney handling this lawsuit:

Settlement date, amount and terms: _____

Do you have a pending workers' compensation claim (circle): YES NO

If yes, specify who the claim is against and the date of the incident: _____

Please provide the name, address and telephone number of the attorney handling this claim:

Have you ever filed a workers' compensation claim (circle): YES NO

If yes, specify who the claim was against and the amounts and terms of the settlement:

EMPLOYMENT INFORMATION

Applicant's Current Employer: _____

Address: _____ Telephone:_____

Hourly pay rate:_____ Hours per week:_____

Date of Employment: _____

Previous Employer:_____

Address: _____ Telephone:_____

Hourly pay rate: _____ Hours per week: _____

Start and End date: _____

Is/was health insurance provided/offered (circle): YES NO

Date eligible: _____ Amount of premium: _____

If not employed, other sources of income and amounts:_____

EMPLOYMENT INFORMATION FOR SPOUSE/SIGNIFICANT OTHER

Current Employer: _____

Address: _____ Telephone:_____

Hourly pay rate: _____ Hours per week: _____

Date of Employment:_____

Previous Employer: _____

Address: _____ Telephone:_____

Hourly pay rate:_____ Hours per week:_____

Start and End date: _____

Is/was health insurance provided/offered (circle): YES NO

Date eligible: _____ Amount of premium: _____

If not employed, other sources of income and amounts:_____

FINANCIAL ASSETS AND RESOURCE INFORMATION

Have you or your spouse been the beneficiary of an inheritance (circle): YES NO

If yes, please specify what was inherited, the value of the inheritance and the date of the inheritance:

Do you or your spouse anticipate receiving an inheritance (circle): YES NO

If yes, estimated amount: _____

Do you or your spouse anticipate receiving income from outstanding loans you have given:

YES _____ NO _____ If yes, please specify to whom the loan was made, the amount of the loan, the payment amount on the loan, and the repayment schedule:_____

Have you or your spouse received or anticipate receiving an IRS tax refund (circle): YES NO

If yes, please specify the amount of the refund and the date received or the anticipated date of reciept: _____

Have you applied for Social Security Disability benefits (circle): YES NO

If yes, please specify the date of the application and the current status of the application, including pending appeals and hearings: _____

Have you ever received a lump sum from Social Security for retroactive pay (circle): YES NO

If yes, please specify how much was received and the date received: _____

Are you currently receiving any loans, grants, or stipends for living expenses (not tuition or books) while attending a post secondary school (circle): YES NO

If yes, please specify the amount received and the time frame it covers: _____

IF YOU OR YOUR SPOUSE HAVE ANY OF THE FOLLOWING ASSETS, PLEASE LIST INCLUDING THE AMOUNTS AND THE ACCOUNT NUMBERS

TYPE	AMOUNT	ACCOUNT NUMBER
One Time Capital Gains		
Mutual Funds		
IRA's		
Retirement Plan		
Annuities		
Investments		
Stocks		
CD's		
Money Markets		
Disability Income		
Savings Accounts		
Checking Accounts		
Bonds		
Any Other Investments OR Money Holding Institutions		

Are you or your spouse listed on a joint account with another individual (circle): YES NO

If yes, please specify the name of the other individual, a description of the account, the holder of the account, and the account number:_____

Are you listed as a dependent on anyone else's Income Tax return (circle): YES NO

If yes, please explain: _____

INCOME/ASSISTANCE INFORMATION			
TYPE	**APPLICANT**	**SPOUSE/OTHER(S)**	
	AMOUNT	**NAME**	**AMOUNT**
Social Security			
SSI/SSD			
V.A. Benefits			
National Guard/Reserve			
BIA/GA Tribal Funds			
Lease Payments			
TANF			
Foster Care			
Salary, Wages, Commissions, Bonuses			
Disability Insurance Payment			
Self-employment			
Unemployment Benefits			
Workers' Compensation			
Vacation/Sick Leave			
Retirement			
Strike Benefits			
Alimony			
Child Support			
Insurance Settlement			
Insurance Face Value			
Scholarship(s) After Tuition/Books			
Loans, Grants After Tuition/Books			
Interest, Dividends, Rents, Royalties, Investment Gains			
IRS Refund			

RESOURCES	
TYPE	**AMOUNT**
WIC	
Food Stamps	
LIEAP	
Subsidized Housing	
Child Care Assistance	
Utility Allowance	
MONTHLY EXPENSES	
TYPE	**AMOUNT**
Court-ordered Child Support	
Rent/Mortgage	
Day Care	
Utilities (Gas/Lights/Water/Telephone)	
Groceries	
Student Loans	
Basic Auto Expenses (Gas/Upkeep)	
Monthly Health or Medical Installment Payments	
Cutomary Monthly Expenses for Medicine & Medical Care	
Court-ordered Alimony	
Automobile Installment Payments Pertaining to One Vehicle	
Other Expenses (Clothing & Intallment Debt for Necessary Household Items)	

INSURANCE	
TYPE	**AMOUNT**
Medical/Dental	
Car	
Life	
House	
Renters	
Lot Rent	
Other (Explain)	

PROPERTY VALUE OF HOME AND OTHER REAL PROPERTY

PROPERTY	CURRENT FAIR MARKET VALUE	-	ENCUMBRANCES	=	EQUITY VALUE
House/Real Estate:		-		=	
Vehicles:		-		=	
Recreational Vehicles:		-		=	
Other (please list)					
		-		=	
		-		=	
		-		=	

BUSINESS PROPERTY

Do you or your spouse own a business (circle): YES NO

If yes, please indicate the name of the business, its location, and the dates of ownership:

Have you or your spouse owned a business in the past (circle): YES NO

If yes, please indicate the name of the business, its location and the dates of ownership:

Equity value of business equipment, property and inventory: _____

Are you or your spouse currently a partner/silent partner in a business (circle): YES NO

If yes, please indicate the name of the business and its location: _____

Have you or your spouse sold or transferred any property within the last 36 months or in the 36 months prior to the onset of this illness (circle): YES NO

If yes, please explain: _____

Are you or your spouse involved in a contract for deed or lease situation either as a seller or as a buyer:

YES _____ NO _____ If yes, please explain: _____

INSURANCE INFORMATION

Do you have a life insurance policy (circle): YES NO

If yes, is it a whole or term life: _____

Limits of the policy: _____ Cash value of policy: _____

Please specify who the beneficiaries are: _____

Have you or your spouse applied or been turned down for health insurance in the past 12 months:

YES _____ NO _____ If yes, why: _____

Have you ever refused health insurance coverage available under COBRA provisions:

YES _____ NO _____ If yes, when: _____

Is health insurance offered through your or your spouse's employer (circle): YES NO

If yes, please state monthly premium amount: _____

Were you in college during the time of this illness or emergency (circle): YES NO

If yes, did you purchase the insurance plan offered through the school (circle): YES NO

Office of
McPherson County Auditor

Jennifer Guthmiller
Auditor

PO Box 390
Leola, SD 57201
Phone: (605) 439-3314
Fax(605) 439-3394

Acknowledgement

I, the undersigned applicant or representative, declare and affirm under the penalties of perjury that this application has been examined by me and, to the best of knowledge and belief, is in all things true and correct. I further acknowledge that I may be prosecuted under the provisions of SDCL 28-13-62.2 if I sign this application knowing the information contained herin is false in whole or in part.

I understand that, under provision of SDCL 28-14, a lien will be filed against me and any personal property or real estate that I own now or have legal interest in or property that I may own in the future for assistance given to me by the county. I further understand that I am required by law to repay the county for assistance given. Should there be no action made to repay this lien, it will be subject to collection.

Applicant: _____ Date:_____

Spouse: _____ Date:_____

Office of
McPherson County Welfare

Jennifer Guthmiller
Auditor & Welfare Director

PO Box 390
Leola, SD 57201
Phone: (605) 439-3314
Fax (605) 439-3394

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, hereby authorize, consent to, and direct the following persons:

_____

and any physician, nurse, clinic, or other medical practitioner who has attended me, or any hospital or other institution of which I have been a patient, to furnish to McPherson County, South Dakota, or its representative, any and all information which may be requested regarding my medical or other condition and treatment, and my history, and to allow them or any physician appointed by them to examine records regarding my condition or treatment.

Specific description of the health information that may be used or disclosed:

- ●Entire Chart
- ●Emergency Room Records
- ●History & Physical Records
- ●Progress Notes
- ●Correspondence Including Medical Corresp.
- ●Consultation Notes
- ●Operative Reports
- ●Discharge Summary
- ●MRI, CT, X-ray Reports, Diagnostic Reports
- ●All Office Notes, Typed and Handwritten
- ●Physical Therapy Records
- ●Laboratory Reports
- ●Pharmacy Records
- ●Nurses' Notes
- ●Mental Health, Alcohol or Drug-Related Records
- ●Itemized Bills

Other:_____

In consideration of the performance of the above, I do hereby release any of the persons named above and any physician, nurse, clinic, or medical practitioner, hospital or other institution from any liability for any apparent violation of right of privacy or of any statute prohibiting or regulating the release of such information.

A photocopy of this Authorization, Consent, Directive, and Release shall be as effective as the original. This authorization, Consent, Directive and Release shall remain in full force an effect until such time as I notify in writing any recipient hereof, or of a copy hereof, of the revocation hereof.

This Release will remain in effect for one year from the date hereof.

Dated this ____ day of _____

Signature_____

Patient's Name_____

Address_____

Social Security Number_____

Birth Date_____

Office of
McPherson County Welfare

Jennifer Guthmiller
Auditor & Welfare Director

PO Box 390
Leola, SD 57201
Phone: (605) 439-3314
Fax(605) 439-3394

REQUEST FOR COUNTY ASSISTANCE

I,_____, state that I am a resident of McPherson County and that I am requesting county welfare assistance under the provisions of SDCL 28-13 and SDCL 28-14. In making this application, I understand that a county poor lien will be place against me and any property that I now have or may later acquire.

I state that I declare myself to be indigent as defined in SDCL 28-13, and that I do not have sufficient money, credit or property to furnish support, and do not have anyone able to support me or to whom I am able to look for support, or I am unable to work because of illness or injury.

I understand that it IS be my responsibility to repay to McPherson County for all funds granted on my behalf. In consideration for this assistance, I hereby agree to pay $_____ per _____, until the assistance is repaid.

I also sign this document as a "Release of Information" to McPherson County to verify and investigate all matters that will help determine my residency and indigency in accordance with SDCL 28-13 and SDCL 28-14 and McPherson County Welfare Guidelines.

*******This form is a request for assistance and not a guaranty of payment. This application will be acted upon by the County Commission of McPherson County and McPherson County Welfare Director for determining eligibility*******

_____ _____
Applicant Signature Date

_____
Address, City, State, Zip Code

_____
Social Security Number

_____ _____
Witness of Signature Date

Office of
McPherson County Welfare

Jennifer Guthmiller
Auditor & Welfare Director

PO Box 390
Leola, SD 57201
Phone: (605) 439-3314
Fax (605) 439-3394

AUTHORIZATION TO RELEASE AND FURNISH INFORMATION

I hereby authorize any person, agency or institution to supply information requested by the Department of McPherson County Welfare, concerning me or my family, and to allow inspection and reproduction of records in his or their possession pertaining to me or my family by any duly authorized representative of the Department of County Welfare.

I further authorized the Department of McPherson County Welfare to release such information to providers or cooperating State or Federal agencies.

I here with release any person, agency or institution from any and all liability to me or my family for supplying such information.

This authorization is given only in connection with its use by the Department of McPherson County Welfare in its administration of its programs and for no other purpose.

_____

Signature of Applicant Social Security # Date

_____

Signature of Spouse or Guardian (If Applicable) SS# Date

_____

Street Address City State Zip

_____

Telephone (Home) (Work)