Application for County Assistance

Funeral Cost

Date:_____ **Case#** _____

Name of Deceased: _____

Current Address: _____

Street Address **City** **State** **Zip Code**

Date deceasd passed away _____ **Where:** _____

If passed away in a hospital or nursing home, please list their prior permanent address:

_____

Street Address **City** **State** **Zip Code**

Please list ALL household members, starting with deceased:

Full Name including maiden name	Relationship to Applicant	Sex	Race	Tribal Affiliation	Birthdate & Birth Place	SS#
	Self					

FUNERAL ARRANGEMENTS

Name of funeral home handling the arrangements_____

Date and place of burial_____

Does deceased have a plot_____ **If yes, where?**_____

MARITAL STATUS

Single(never been married)_____ Married_____ Separated___ Divorced____ Widow(er)____

Married to _____ Date_____ City_____ State_____

Divorced:_____ Date _____

Separated:_____ Date _____

DECEASED'S VETERAN STATUS

List any veterans in the household

Name_____ Branch_____ Dates_____ Type of Discharge_____

Not a Veteran_____

MONTHLY OBLIGATIONS

Rent/ Mortgage		**Day Care**	
Utilities (gas, lights, water)		**Court-ordered Child Support**	
Insurance (medical, car, life)		**Car payment**	
		Rent to own	
Phone/ cell phone		**medical/medication**	
Cable		**Other**	

VEHICLES

Year_____ Make_____ Balanced Owed_____

Year_____ Make_____ Balanced Owed_____

DECEASED EMPLOYMENT HISTORY

List current job and last 3 jobs

Employer	Job Title	Hours/wk	Wages	Start/End Date	Why left

DECEASED'S OTHER INCOME/ASSETS

INCOME TYPE	Monthy amount	Assets	Value/Amount
SSDI		HOME	
SSI		VEHICLE 1	
SS		VEHICLE 2	
VETERAN BENEFITS		SAVINGS ACCOUNT	
RETIREMENTS		CHECKINGS ACCOUNT	
RENTAL/LAND		STOCK/BONDS	
BURIAL INSURANCE		CD'S/ IRA'S	
LIFE INSURANCE		INHERITANCE/TRUSTS	
OTHER		401 K PLAN	
		LAND OWNED	

FAMILY CONTRIBUTION

Please list ALL immediate family members of the deceased

I DECLARE AND AFFIRM, UNDER THE PENALTIES OF PERJURY AND DENIAL OF BENEFITS, THAT THE ABOVE INFORMATION GIVEN IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND CORRECT.

SIGNATURE _____ **DATE** _____

Burial Family Contribution

This must be completed for every immediate family member

Name & Relationship	Adress	Occupation	Annual Household Income	Number of Household Members

Office of
McPherson County Auditor

Lindley Howard
Auditor/Welfare Director

PO Box 390
Leola, SD 57456
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

Lindley Howard
Auditor/Welfare Director

PO Box 390
Leola, SD 57456
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

Lindley Howard
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)