INFORMATION / REQUIREMENTS for
MEDICAL / HOSPITAL ASSISTANCE

PRE-APPROVAL IS NEEDED FOR SERVICES PRIOR TO PROCEDURE(S), SURGERY, HOSPITAL STAY(S) AND OR DENTAL SERVICES UNLESS TRUE EMERGENCY THROUGH THE EMERGENCY ROOM. **TURNER COUNTY DOES NOT NORMALLY PAY FOR DOCTOR VISITS OR AMBULANCE BILLS.** ALONG WITH THE APPLICATION AND INFORMATION PROVIDED, A WORKSHEET IS WORKED TO DETERMINE ELIGIBILITY AND A DECISION WILL BE MADE.

CLIENT IS TO PROVIDE THE FOLLOWING INFORMATION:

- A completed Turner County Assistance Application
- Dr. License or Picture I.D.
- Social Security card(s) – for everyone in the household
- Proof of Residency (at time of services received)

INCOME:

- Last Year's Income Tax or W-2(s) from place(s) of employment
- Last Pay stub with Year To Date Income Total or Check stubs for PRESENT YEAR
- 401k, IRA, CD information, property lease income
- Most recent Bank Statement(s), Checking and Savings - 3 recent months of each
- Verification of any Child Support or Alimony received

EXPENSES:

- Housing payment verification (ie: Mortgage, Deed **or** signed lease agreement)
- Home insurance verification (if paid separately from mortgage)
- Property tax statement
- Utility Bills – last 6 months
- Car payment verification
- Car insurance verification
- Prescriptions taken over the last 3 months (your pharmacy will print out)
- Verification of payments on any **other** medical bills that you are paying on
- Verification of Child Support and or Alimony paid out
- Verification of Day Care Fees - last 6 months
- Life Insurance – Premium and value
- IRA, 401k, or CD Contribution(s)

IS THERE ANOTHER ADULT IN THE HOUSEHOLD?

- If married, information for both individuals is required ~ if single, only information for individual applying is required.

FOR PRE-APPROVAL OF PROCEDURES:

YOU MUST HAVE A STATEMENT from the doctor/surgeon/dentist explaining procedure needed and why procedure is necessary **BEFORE procedure** is to be done, along with above information and a completed application. Individual is responsible for the initial doctor visit.

NO PRE-APPROVAL FOR PROCEDURE ~ NO ASSISTANCE GRANTED

BE AWARE THAT A LIEN FOR THE AMOUNT OF ASSISTANCE WILL BE FILED AGAINST YOU BY THE COUNTY, WHICH YOU MUST PAY BACK IN FULL.

APPLICATION FOR COUNTY ASSISTANCE

Telephone:_____ Email:_____ Date:_____

What do you need assistance for?_____ Amount: $_____

Section 1: Personal Data

_____

Last Name **First** **Middle** **DOB** **SSN**

_____

Address-Street **City** **State** **Zip**

I have lived at the above address since:_____ I Previously lived in: _____
MO/YR City/State

Other Household Members:

Name	DOB	Relationship	SSN

Marital Status: ___Single __ Married ___Separated ___Divorced ___Widowed

If Separated or living separately: Spouses Name: _____

Spouses Address:_____
(if living separately) Street City State

If formerly married: _____
Spouses Name Date Married Date Divorced/Deceased

Are you a Veteran? ___ yes ___ no Other household member(s) a Veteran? ___ yes ___no

Education:

Completed High School: ____Yes ____No GED: _____ College:_____

Currently Enrolled? ____ If so, Name/Location of School:_____

Have you asked family members for assistance? _____ Yes _____ No
Family member(s) that assisted: _____
Name Relationship

If Medical Assistance: Have you applied/worked out a payment plan with the health care provider that provided the services you are now applying for? Yes _____ No_____ As per SDCL: 28-13-33.2
If so, what are the payments they offered you? $ _____ per month or $ _____per year

Do you have Health Insurance? Yes ___ No ___ **When did you last have health insurance?** _____

Is health insurance offered through your work or school? Yes ____ No ____ N/A ____

Employment History (List your last three jobs)

Applicant:

Employer	Dates (Start/End)	Job Title	Wage	Hours Worked	Reason For Leaving	Contact Information (Name phone number, address)
			$			
			$			
			$			

If you lost any of the above listed jobs, did you apply for unemployment? _____ If so, list date, and decision of unemployment benefits: _____

Have you applied for Social Security Disability? _____ did they approve? _____

If you claim to be unable to work because of a disability, please attach a copy of your Social Security Disability Award Letter and relevant medical records which describe your disability.

Other Adult Household Member: (Use additional sheet for additional adults in HH)

Employer	Dates (Start/End)	Job Title	Wage	Hours Worked	Reason For Leaving	Contact Information (Name phone number, address)
			$			
			$			
			$			

If you lost any of the above listed jobs, did you apply for unemployment? _____ If so, list date, and decision of unemployment benefits: _____

Have you applied for Social Security Disability? _____ did they approve? _____

If you claim to be unable to work because of a disability, please attach a copy of your Social Security Disability Award Letter and relevant medical records which describe your disability.

Section 2: Assets and Debts

Assets:	Name of Institution/Description:	Value/Amount:
CASH		$
Bank Account: checking or savings		$
Bank Account: checking or savings		$
Stocks/Bonds/Trusts/CD's/IRA's		$
Real Estate/Land		$
Auto		$
Auto		$
Motorcycle/ ATV/Boat/RV etc.		$
Life Insurance or Burial Policy		$
Other		$

*Any form of anticipated income / gifts: Tax refund, inheritance, sale of property or belongings? _____

_____

Monthly Obligations:	Amount Paid/Due:	Name of Creditor:
Rent (Apt__ House__ Mobile Home__ Lot Rent__)	$	
Electricity	$	
Heat	$	
Water/Sewer/Garbage	$	
Day Care	$	
Insurance – Medical/Health/Prescription	$	
Insurance - Vehicle	$	
Insurance – Renters (home owners ins. only if not included in mortgage)	$	
Child Support /Alimony (paid)	$	
Gasoline	$	
Food (other than or above food stamps) / Hygiene/Household Necessities	$	
Other	$	

Loans and/or Bills	Name of Creditor	Monthly Payment	Total Owed
Mortgage		$	$
Auto Loan		$	$
Auto Loan		$	$
Student Loan(s)		$	$
Payday or Title Loans		$	$
Rent To Own		$	$
Garnishment/Judgement		$	$
Credit Card		$	$
Credit Card		$	$
Medical Bill		$	$
Medical Bill		$	$
Medical Bill		$	$
Personal		$	$

Landlord Information:

_____ #

Name Address Phone Number

Section 3: Income Information

	Applicant - Amount Received	**Other HH Member** - Amount Received
Social Security (SSDI/SSI/SS)	$	$
Military/Veterans Benefits	$	$
Tribal Benefits	$	$
WAGES (employment) Gross Income	$	$
TAX REFUND	$	$
LIEAP (Energy Assistance)	$	$
TANF	$	$
WIC	$	$
SNAP / Food Stamps	$	$
Subsidized Housing	$	$
Alimony (received)	$	$
Child Support (received)	$	$
Unemployment	$	$
Workers Compensation	$	$
Foster Care	$	$
Pension/Retirement/401k	$	$
Lease/Rental Income (Received)	$	$
Strike Benefits	$	$
Insurance (Settlement or cash value)	$	$
Other Income	$	$
Loans/Grants/scholarships	$	$

Section 4: Economic Assistance - Miscellaneous Information

Have you applied for assistance with any organization?

Name of Charity	Date of request	Amount or reason for denial
		$
		$
		$
		$
		$

Section 5: Declaration

- I swear or affirm that the statements made in this application are true and correct to the best of my knowledge. Knowingly supplying false information to a welfare official is a Felony under South Dakota law.
- I authorize Turner County to make all necessary inquiries in connection with this application.
- **I understand that if I receive assistance, Turner County will file a lien against me for the amount of the assistance given, which I agree to reimburse the County in full. If I do not, Turner County will pursue collection.**

X_____

Applicant

_____

Date

_____

Welfare Director

Turner County Welfare
PO Box 370
Parker, SD 57053-0370
Phone: 605/297-3153

AUTHORIZATION FOR RELEASE OF INFORMATION

Applicants Name: _____

Address: _____

_____

Date of Birth: _____ Social Security Number: _____

I, the above named applicant, hereby authorize any individual, agency, institution, or facility, including the Social Security Administration, Department of Social Services and the Department of Labor to release information to Turner County Welfare concerning myself and/or my family members and to allow inspection and reproduction of records in the individuals, agencies, institutions, or facilities possession, pertaining to myself and/or my family members. I further authorize Turner County Welfare to release such information to providers or cooperating state or federal agencies.

This authorization is given only in connection with its use by Turner County Welfare in the administration of its programs under the provisions of SDCL chapters 28-13, 28-13A, and 28-14. I understand that the information will be considered confidential and shared only with individuals, agencies, institutions, or facilities assisting with my financial needs. I hereby release any person, agency or institution from any and all liability to me or my family members for supplying such information.

A photocopy of this release shall be as valid as the original and shall continue in effect until such time as I notify the county that it is no longer valid.

Dated this _____ (day) day of _____ (month), 20_____ (year).

X_____
Applicant's Signature

X_____
Spouse's Signature (if applicable)

_____ _____
Signature of parent, guardian, or authorized representative If client/patient is either a minor or incapacitated

Relationship to Applicant

CONTRACT FOR REPAYMENT OF COUNTY ASSISTANCE

Name: _____

SSN: _____ DOB(s): _____

Name: _____

SSN: _____ DOB(s): _____

Address: _____
Street *City/Town* *State* *Zip*

Phone #'s: _____

I, the above-named, acknowledge that I have received financial assistance from the Turner County Welfare Office pursuant to the provisions of SDCL 28-13 and hereby enter into agreement with Turner County for the repayment of said assistance. ***I understand that a lien in the amount of the assistance paid on my behalf will be filed against me.*** I acknowledge that such assistance includes that which I have specifically requested myself and that which I have authorized institutions to submit claims to Turner County on my behalf.

Under the provisions of this contract I agree to repay Turner County the amount of all assistance paid on my behalf until the amount due and owing is paid in full. I understand that this contract may be amended with each occurrence of assistance provided to me or on my behalf. I acknowledge that the below record of assistance is only a representation of assistance provided on my behalf and does not represent payments I have made to Turner County. I understand that upon request, I may obtain a full record of my account, including payments I have made.

Date of Assistance	Type of Assistance	Amount of Assistance	Applicant Initial	Spouse or Other Adult HH Member Initial
		$		
		$		

I agree to pay Turner County $_____ per month, beginning _____.

I understand that I may make monthly payments in person at the Turner County Treasurer's Office **or** mail monthly payments (check or money order) to: Turner County Welfare, PO Box 370, Parker, SD 57053.

If I fail to comply with this agreement, I understand Turner County will pursue the full amount of the lien filed against me with a collection agency to recover the amount Turner County has paid on my behalf.

I have read and agree to the terms and conditions of the above agreement.

Dated this _____ (day) day of _____ (month), 20____ (year).

Signature: **X**_____

Signature: **X**_____

Turner County Welfare Director: _____ Date: _____