

**APPLICATION FOR  
MEDICAL ASSISTANCE**

**Type of Assistance Requested:** \_\_\_\_\_  
**Amount Requested:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**APPLICANT INFORMATION:**

Applicant's Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_  
AKA (also known as): \_\_\_\_\_ County of Residence: \_\_\_\_\_  
Maiden Name (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Are there any other Social Security numbers that you have used in the past? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list those numbers: \_\_\_\_\_

Marital Status (Circle one):      Married      Separated      Divorced      Single      Widowed

If married, give town, state and date of marriage: \_\_\_\_\_  
If formerly married, list name of former spouse(s), date(s) of marriage, divorce, death or separation: \_\_\_\_\_  
\_\_\_\_\_

**SPOUSE INFORMATION:**

Spouse's Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_  
AKA (also known as): \_\_\_\_\_ County of Residence: \_\_\_\_\_  
Maiden Name (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

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 INFORMATION:**

Full name: \_\_\_\_\_  
AKA (Also known as): \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PLEASE LIST ALL OTHER HOUSEHOLD MEMBERS:**

Full Name: _____	SSN: _____	DOB: _____	Relationship: _____
Full Name: _____	SSN: _____	DOB: _____	Relationship: _____
Full Name: _____	SSN: _____	DOB: _____	Relationship: _____
Full Name: _____	SSN: _____	DOB: _____	Relationship: _____
Full Name: _____	SSN: _____	DOB: _____	Relationship: _____
Full Name: _____	SSN: _____	DOB: _____	Relationship: _____
Full Name: _____	SSN: _____	DOB: _____	Relationship: _____

Does anyone besides yourself claim you as a dependent on their income tax? \_\_\_\_\_

**CITIZEN INFORMATION:**

Are you a citizen of the United States? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, what is your citizen status? \_\_\_\_\_  
Are you a registered voter? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, where are you registered and in what County? \_\_\_\_\_  
If you have children, where are they enrolled in school? \_\_\_\_\_

**HISTORY OF RESIDENCE:**

How long have you lived in Lake County? \_\_\_\_\_  
Previous address: \_\_\_\_\_ County: \_\_\_\_\_  
Did you / spouse/significant other move to Lake County for the purposes of medical care?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

**MEDICAL INFORMATION:**

Is there any third party coverage? A) Medicare B) Medicaid C) Veteran  
D) Health Insurance E) Native American HIS  
F) Other \_\_\_\_\_

Was your illness an emergency? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, date of emergency: \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
If no, please list date of scheduled service: \_\_\_\_\_

Has the doctor authorized you to return to work?: Yes \_\_\_\_\_ No \_\_\_\_\_  
If no, when is your anticipated date of return?: \_\_\_\_\_

Have you tried or have you been making reasonable payments to the hospital? Yes \_\_\_\_\_ No \_\_\_\_\_  
What is the total bill? \_\_\_\_\_  
What is the amount of your monthly payment? \_\_\_\_\_  
How much have you paid on this bill? \_\_\_\_\_

Have you tried applying for Medicare, Medicaid, or SSI? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, which one have you applied for and what is the date of your application? \_\_\_\_\_  
\_\_\_\_\_

Are you in an appeal process with SSI? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how many appeals have you made? \_\_\_\_\_  
Have you gone before the judge with your appeal? \_\_\_\_\_

Are you a Native American: Yes \_\_\_\_\_ No \_\_\_\_\_  
If you are a Native American, are you an enrolled tribal member? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what tribe? \_\_\_\_\_

Are you a veteran? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, are you enrolled with the V.A. Hospital?: Yes \_\_\_\_\_ No \_\_\_\_\_

Were you a college student during the time of this illness or emergency? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, did you purchase the insurance plan offered through the school? Yes \_\_\_\_\_ No \_\_\_\_\_

**LEGAL CLAIM INFORMATION:**

Are you or your spouse currently involved in a lawsuit? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, briefly explain: \_\_\_\_\_

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

\_\_\_\_\_

Have you or your spouse ever been involved in a lawsuit? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Settlement date, amount and terms: \_\_\_\_\_

\_\_\_\_\_

Do you have pending workers' compensation claim? 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?: Yes\_\_\_\_\_ No\_\_\_\_\_

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

\_\_\_\_\_

**EDUCATION:**

Are you a post secondary student? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what school do you attend and the name of the town it is located in? \_\_\_\_\_

\_\_\_\_\_

How much money are you receiving yearly from student loans? \_\_\_\_\_

When do you anticipate paying those loans back? \_\_\_\_\_

**APPLICANT'S EMPLOYMENT INFORMATION:**

Applicant's current employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Hourly pay rate: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Date of employment: \_\_\_\_\_

Job description: \_\_\_\_\_

Is health insurance provided or offered? Yes\_\_\_\_\_ No\_\_\_\_\_

Date eligible: \_\_\_\_\_ Amount of premium: \_\_\_\_\_

Applicant's previous employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Hourly pay rate: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start and end dates of employment: \_\_\_\_\_ Why left? \_\_\_\_\_  
Job description: \_\_\_\_\_  
Was health insurance provided or offered? Yes \_\_\_\_\_ No \_\_\_\_\_  
Date eligible: \_\_\_\_\_ Amount of premium: \_\_\_\_\_  
If not employed, other sources of income and amounts: \_\_\_\_\_  
\_\_\_\_\_

**EMPLOYMENT INFORMATION FOR SPOUSE OR SIGNIFICANT OTHER:**

Spouse's or significant others' current employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
Hourly pay rate: \_\_\_\_\_ Hours per week: \_\_\_\_\_  
Job description: \_\_\_\_\_  
Date of employment: \_\_\_\_\_  
Is health insurance provided or offered? Yes \_\_\_\_\_ No \_\_\_\_\_  
Date eligible: \_\_\_\_\_ Amount of premium: \_\_\_\_\_

Spouses' or significant others' previous employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
Hourly pay rate: \_\_\_\_\_ Hours per week: \_\_\_\_\_  
Job description: \_\_\_\_\_  
Start and end dates of employment: \_\_\_\_\_ Why Left? \_\_\_\_\_  
Was health insurance provided or offered? 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/significant other been the beneficiary of an inheritance?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify: What was inherited: \_\_\_\_\_  
The value of the inheritance: \_\_\_\_\_  
The date of the inheritance: \_\_\_\_\_

Do you or your spouse/significant other anticipate receiving an inheritance?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes: The estimated amount: \_\_\_\_\_

Do you or your spouse/significant other anticipate receiving income from outstanding loans you have given?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify: Whom the loan was made to: \_\_\_\_\_  
The amount of the loan: \_\_\_\_\_  
The payment amount on the loan: \_\_\_\_\_  
The repayment schedule: \_\_\_\_\_

Have you or your spouse/significant other received or anticipate receiving an IRS tax refund?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify: Amount of refund: \_\_\_\_\_  
Date received or anticipated receipt: \_\_\_\_\_

Have you applied for Social Security Disability benefits?: Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please specify: Date of application: \_\_\_\_\_  
 Current status of the application: \_\_\_\_\_  
 Pending appeals and hearings: \_\_\_\_\_

Have you ever received a lump sum from Social Security for retroactive pay?  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please specify how much was received and date received. \_\_\_\_\_

Are you currently receiving any loans, grants, or stipends for living expenses (not tuition or books) while attending a post secondary school? :  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please specify: The amount received: \_\_\_\_\_  
 The time frame it covers: \_\_\_\_\_

**PROPERTY VALUE OF HOME AND OTHER REAL PROPERTY:**

<i>Property</i>	<i>Current Fair Market Value</i>	<i>Encumbrances</i>	<i>Equity Value</i>
House / Real Estate	-	=	
Vehicles	-	=	
Recreational Vehicles:	-	=	
Other (please list)	-	=	
Other (please list)	-	=	
Other (please list)	-	=	

Do you or your spouse/significant other currently own a business? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please specify: Name of the business: \_\_\_\_\_  
 Location of business: \_\_\_\_\_  
 Dates of ownership: \_\_\_\_\_  
 Equity value of equipment, property and inventory: \_\_\_\_\_

Are you or your spouse/significant other currently a partner/silent partner in a business?  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please specify: Name of the business: \_\_\_\_\_  
 Location of business: \_\_\_\_\_

Have you or your spouse/significant other sold or transferred any property within the last 36 months or in the 36 months prior to the onset of this illness?  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Are you or your spouse/significant other involved in a contract for deed or lease situation either as a seller or a buyer?  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_



If yes, please specify: Name of other individual: \_\_\_\_\_  
 Description of the account: \_\_\_\_\_  
 Holder of the account/ name of company: \_\_\_\_\_  
 Account number: \_\_\_\_\_

**RESOURCES:**

<i>TYPE</i>	<i>AMOUNT</i>
WIC:	
Food Stamps (SNAP)	
Low Income Energy Assistance Program (LIEAP)	
Subsidized Housing:	
Child Care Assistance:	
Utility Allowance:	
Has any household member received assistance from any other agency in the past 30 days:	
Explain: _____	
Does any household member expect to receive income this month that's not previously reported:	
Explain: _____	

**MONTHLY EXPENSES:**

<i>TYPE</i>	<i>AMOUNT</i>
Actual rent paid	
Scheduled principal and interest payments for a personal residence	
Property taxes and homeowners insurance costs	
Utilities: Heating (Liquid propane, Natural Gas, Fuel Oil	
Utilities: Electricity	
Utilities: Water	
Utilities: Phone	
Childcare expenses related to work schedules (minus child care assistance)	
Groceries (minus SNAP benefits)	
Household supplies and toiletries	
Basic auto expenses, gas, and upkeep	
Health insurance (out-of-pocket)	
Life insurance (out-of-pocket)	
Auto insurance (out-of-pocket)	
Monthly health or medical installment payments:	
Customary monthly expenses for medicine & medical care	
Court ordered child support	
Court ordered alimony	
Automobile installment payments (pertaining to one vehicle only)	
Other expenses (clothing & installment debt for necessary household items)	

**INCOME / ASSISTANCE INFORMATION:**

<i>TYPE</i>	<i>APPLICANT</i>		<i>SPOUSE / OTHERS</i>	
	<i>Amount</i>		<i>Name</i>	<i>Amount</i>
Social Security:				
SSI / SSD				
VA Benefits:				
Nat'l Guard / Reserve:				
BIA / GA Tribal Funds:				
Lease Payments:				
TANF:				

Foster Care:			
Salary and wages and tips			
Commissions & bonuses			
Disability Insurance payment			
Self-employment:			
Unemployment Benefits:			
Workers' Compensation:			
Vacation / Sick Leave:			
Retirement / Pensions			
Strike Benefits:			
Alimony:			
Child Support:			
Insurance Settlement:			
Insurance Face Value:			
Scholarships (after tuition/books)			
Loans & grants (after tuition/books)			
Interest and dividends			
Rents, royalties, investments			
IRS refund			

**DECLARATION**

I will supply all necessary information to support this application for county assistance.

I authorize a representative of the county to make all necessary inquiries to verify claims on my application.

I understand that the making of any false statement as to financial status or other required information in the above application with knowledge of such falsity, may be a crime in violation of SDCL 28-13-16.2.

I understand that, in accordance with SDCL 28-14, a lien will be filed against me and any personal property or real property that I now own, or have legal interest in, or may own in the future, for any assistance given to me by Lake County. I further understand that I am required by law to make repayments to Lake County for assistance given. Should there be no action made on repaying this lien, it will be subject to collection.

I understand that assigning or transferring any property at any time before or after making an application for poor relief for the purpose of becoming eligible for assistance, may be a crime in violation of SDCL 28-13-43.

I swear and affirm that the statements made herein are true and correct and I have provided all necessary documentation to validate my claim for county poor relief.

\_\_\_\_\_  
Applicant signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-applicant signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT**

**STOP:** *The signature(s) below requires a Notary Public. Your signature must be witnessed by a Notary. All adults in household must have notarized signature on this application. Notaries are available in the Lake County Courthouse, banks, law offices, etc.*

I, (We) 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 my knowledge and belief, is in all things true and correct. I further acknowledge that I may be prosecuted under the provisions of SDCL 28-13-16.2 if I sign this application knowing the information contained herein is false in whole or in part.

I (We) understand that, under the provisions of SDCL 28-14, a lien will be filed against me and any personal property or real estate that I now own or have a legal interest in or property that I may own in the future for assistance given 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: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Date of signing: \_\_\_\_\_

Spouse/Co-applicant: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Date of signing: \_\_\_\_\_

STATE OF SOUTH DAKOTA )  
 )ss  
COUNTY OF LAKE )

**NOTARY**

Subscribed and sworn to before me, the undersigned officer, by the above named person(s) for the purposes therein contained.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

( S E A L )

\_\_\_\_\_  
Notary Public South Dakota  
My Commission Expires: \_\_\_\_\_