# 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

| Asset | 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: <u>Economic Assistance</u> - Miscellaneous Information**

Have you applied with The Salvation Army, The Journey Home, local churches, Aberdeen Housing Authority, GROW SD, or have you been referred to CASSP and or Safe Harbor or any other organizations for assistance?

| 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 Brown County to make all necessary inquiries in connection with this application.
- **I understand that if I receive assistance, Brown 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, Brown County will pursue collection.**

_____
Applicant

_____
Date

_____
Welfare Director

**Brown County Welfare**
25 Market Street  Suite 1
Aberdeen, SD  57401-4227
Phone: 605/626-7125

# 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 Brown 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 Brown 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 Brown 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 of _____, 20_____.
(day) (month) (year)

**X**_____
Applicant's Signature

**X**_____
Spouse's Signature (if applicable)

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

# 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 Brown County Welfare Office pursuant to the provisions of SDCL 28-13 and hereby enter into agreement with Brown 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 Brown County on my behalf.

Under the provisions of this contract I agree to repay Brown 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 Brown 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 Brown County $_____ per month, beginning _____.

I understand that I may make monthly payments in person at the Brown County Treasurer's Office **or** mail monthly payments (check or money order) to: Brown County Welfare, 25 Market St. Suite 1, Aberdeen, SD 57401.

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

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

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

Signature: **X**_____

Signature: **X**_____

Brown County Welfare Director: _____ Date: _____