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: 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: ______________________________

PLEASE COMPLETE SPOUSE INFORMATION 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 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: Yes ______ No ______
If yes, please explain: ____________________

MEDICAL INFORMATION

Was this illness an emergency: 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: Yes ________ No ________

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

Are you a Native American: Yes ___ No ___ Are you a Veteran: 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 ____ Enrolled with VA Hospital Yes __ No __

Have you tried or have you been making reasonable payments to the hospital: Yes ___ No ___

If yes, what was 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: 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: 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: 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: ____________________

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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: ____________________

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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: 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: 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: 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: 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: Yes ___ No ___

If yes, please specify the amount of the refund and the date received or the anticipated date of receipt: ______________________

Have you applied for Social Security Disability benefits: Yes ______ No ______

If yes, please specify the date of 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: 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 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 AND NAME OF BANK
One Time Capital Gains:		
Mutual Funds:		
IRA's		
Retirement Plan:		
Annuities:		
Investments:		
Stocks:		
CD's		
Money Markets:		
Disability Income:		
Savings:		
Checking Accounts:		
Bonds:		
Any Other Investments Or Money Holding Institutions:		

Are you or your spouse listed on a joint account with another individual: Yes ____ No ____

Are you listed as a dependent on anyone else's Income Tax return: Yes ____ No ____

If yes, please explain: ____________

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

INCOME/ASSISTANCE INFORMATION

TYPE	APPLICANT	SPOUSE/OTHER(S)	
	Amount	*Name*	*Amount*
Social Security:			
SSI/SSD:			
VA Benefits:			
Nat'l Guard/Reserve:			
BIA/GA Tribal Funds:			
Lease Payments:			
TANF:			
Foster Care:			
Salary, Wages, Commissions, Bonuses:			
Disability Insurance Payment:			
Self-employment:			
Unemployment Benefits:			
Workers' Comp.:			
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:	
Customary Monthly Expenses for Medicine & Medical Care:	
Court-ordered Alimony:	
Automobile Installment Payments Pertaining to One Vehicle:	
Other Expenses (Clothing & Install-ment 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		Encumb rances		Equity Value
House/Real Estate:	______	-	______	=	______
Vehicles:	______	-	______	=	______
Recreational Vehicles:	______	-	______	=	______
Other (please list):	______	-	______	=	______
	______	-	______	=	______
	______	-	______	=	______

BUSINESS PROPERTY

Do you or your spouse currently own a business: 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: Yes ____ No ____

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

____

Equity value of equipment, property and inventory: ______________

____

Are you or your spouse currently a partner/silent partner in a business: Yes ____ No ____

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

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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: Yes ____ No ____
If yes, please explain: ______________

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Are you or your spouse involved in a contract for deed or lease situation either as a seller or a buyer: Yes _____ No _____ If yes, please explain: ______________________

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INSURANCE INFORMATION

Do you have a life insurance policy: Yes _____ No _____

If yes, is it whole life or term life: ______________________

Limits of policy: ______________________ Cash value of policy: ______________

Please specify who the beneficiaries are: ______________________

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Have you or your spouse applied or been turned down for health insurance in the past 12 months: Yes No If yes, why: ______________________

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Have you or your spouse ever been eligible for health insurance under COBRA provisions: Yes _____ No _____ If yes, what was the premium amount: ______________

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: Yes _____ No _____

If yes, please state monthly premium amount: ______________________

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 _____

CITIZEN INFORMATION

Are you a citizen of the United States: Yes _____ No _____

If not, what is your citizen status:

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 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 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: ______________________________ Date: ______________

Spouse: ______________________________ Date: ______________

GENERAL RELEASE OF INFORMATION

NAME: ____________________

SSN: ____________________

BIRTH DATE: ____________________

ADDRESS: ____________________

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I, ____________________, hereby authorize any individual, agency, institution, or facility to supply information to the county of my residence concerning myself and/or my family and to allow inspection and reproduction of records in the individual's agency's, institution's, or facility's possession pertaining to myself and/or my family. I further authorize the county to release such information to appropriate vendors or cooperating state, federal, non-profit or private agencies.

This authorization is given only in connection with its use by the county 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.

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.

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Applicant's Signature Date

Witness: ____________________

Address: ____________________

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Please forward the requested information to:

CASEWORKER: ____________________

COUNTY: ____________________

ADDRESS: ____________________

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Summary Of Notice Of Privacy Practices

Connie Atkinson – Privacy Officer
Auditor Office 578-1941
90 Sherman Street, Deadwood, SD 57732

THIS SUMMARY IS FOR YOUR CONVENIENCE AND IS NOT A SUBSTITUTE FOR READING THE ENTIRE NOTICE OF PRIVACY PRACTICES.

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, IN ACCORDANCE WITH THE PRIVACY REGULATIONS CREADTED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996. (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

Lawrence County is dedicated to uphold the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information.

I. Information That May Be Used or Disclosed Without Your Authorization:

1. Information for your health care treatment
2. Payment of your treatment
3. For Regular Health Care Operations
4. When Legally Necessary and required by law
5. For Governmental Benefits
6. For Public Health and Safety
7. For Research using de-identifiable information
8. To Family, Friends and Others involved in your care

II. Uses and Disclosures That Require Your Authorization:

For other situations not described in the Notice of Privacy Practice, Lawrence County will request your written Authorization. You may revoke your authorization at any time, except when we have acted in reliance on your authorization.

III. Your Health Information Rights:

1. You may request restrictions on the Use and Disclosure of your health information.
2. You may request confidential communications you receive from us.
3. You may see and copy your health information maintained.
4. You may request a change in your health records if you believe they are inaccurate.
5. You may request a list of disclosures made of your health records.
6. You may request a paper copy of the complete Notice of Privacy Practice.
7. You may file a complaint to the Privacy Officer if you feel your rights have been violated. You will not be penalized for filing a complaint.

There are a number of limitations and exceptions to these rights, which are explained in the full version of the Notice of Privacy Practice. You may request a paper copy from the Department or the Privacy Officer.

IV. Changes to the Notice Of Privacy Practices:

Lawrence County reserves the right to amend the Notice of Privacy Practices at any time in the future and to make the new provisions effective for all information maintained.

INFORMATION NEEDED TO COMPLETE APPLICATION FOR ASSISTANCE

FOR: ____

COUNTY: ______________________ Date: ________________

In order for the county to be able to process your application for medical assistance as quickly as possible, it is essential for you to provide the requested information.

If you have any questions, please call Bruce Outka at 722-4167.

1. List of all cars, recreational vehicles, boats, motorcycles or any other motor vehicles, with the monthly payment and loan balance.
2. Cash on hand and in bank accounts, CDs, trusts, annuities, investments and capital gains.
3. A copy of last year's (or current if filed) completed income tax return.
4. Receipts relating to monthly expenses, including rent or mortgage payments, utilities, child care, health/life insurance, auto insurance, child support etc.
5. Information concerning proof of student status, school grants, stipends.
6. Record of gross income for the past 60 days, including VA 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.
7. Record of income earned through interest, dividends, rents, royalties, and investment gains.
8. Proof of the availability of health insurance from employer(s), if offered, and the amount that is the household's responsibility.
9. Copy of all medical bills for which you are seeking assistance and any payments made.
10. Copies of denials from Medicaid, IHS, if applicable.
11. Medical records and attending physician statements pertaining to the hospital bill for which you are seeking assistance.
12. Signed release of information.
13. Other:

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