DAVISON COUNTY APPLICATION FOR MEDICAL ASSISTANCE

PLEASE COMPLETE THE FOLLOWING FOR IN ITS ENTIRETY. IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM, PLEASE CALL 605-995-8611.

APPLICANTS FULL NAME: ____________________

AKA (ALSO KNOWN AS): ____________________

MAIDEN NAME: ____________________

SOC. SECURITY #: ____________________ DATE OF BIRTH ____________________

ADDRESS: ____________________

HOW LONG AT THIS ADDRESS: ____________________ PREVIOUS ADDRESS: ____________________

PHONE NUMBER HOME: ____________________ WORK ____________________

ARE THERE ANY OTHER SOC. SECURITY #'S THAT YOU HAVE USED IN THE PAST?

☐ YES ☐ NO IF YES #: ____________________

PLEASE FILL OUT SPOUSE INFORMATION IF NOT LEGALLY DIVORCED:

SPOUSE FULL NAME: ____________________

AKA (ALSO KNOWN AS): ____________________

MAIDEN NAME: ____________________

SOC. SECURITY #: ____________________ DATE OF BIRTH ____________________

ADDRESS: ____________________

PHONE NUMBER HOME: ____________________ WORK ____________________

ARE THERE ANY OTHER SOC. SECURITY #'S THAT YOU HAVE USED IN THE PAST?

☐ YES ☐ NO IF YES #: ____________________

SIGNIFICANT OTHER NOT LEGALLY MARRIED TO:

FULL NAME: ____________________

AKA (ALSO KNOWN AS): ____________________

SOCIAL SECURITY #: ____________________ DATE OF BIRTH ____________________

PLEASE LIST ALL IN THE HOUSEHOLD YOU ARE RESPONSIBLE FOR:

NAME: ____________________

SOC. SEC.#: ____________________ DATE OF BIRTH: ____________________

NAME: ____________________

SOC. SEC.#: ____________________ DATE OF BIRTH: ____________________

NAME: ____________________

SOC. SEC.#: ____________________ DATE OF BIRTH: ____________________

NAME: ____________________

SOC. SEC.#: ____________________ DATE OF BIRTH: ____________________

DOES ANYONE BESIDES YOURSELF CLAIM YOU AS A DEPENDENT ON THEIR INCOME TAX? ____________________

HISTORY OF RESIDENCE:

HOW LONG HAVE YOU LIVED IN BEADLE COUNTY? ____________________

PREVIOUS ADDRESS: ____________________

MEDICAL INFORMATION:

WAS THIS ILLNESS AN EMERGENCY? ☐ YES ☐ NO DOCTOR'S NAME ____________________

IF YES, PLEASE EXPLAIN: ____________________

____

____

____

HAS YOUR DOCTOR RELEASED YOU FOR WORK DUTY YET? ☐ YES ☐ NO

IF NO, WHEN IS YOUR ANTICIPATED DATE OF RETURN: ____________________

ARE YOU ELIGIBLE FOR EITHER INDIAN HEALTH SERVICES OR MEDICAL SERVICES THROUGH THE VETERAN'S HOSPITALS? ☐ YES ☐ NO

HAVE YOU TRIED/HAVE YOU BEEN MAKING REASONABLE PAYMENTS TO THE HOSPITAL? ☐ YES ☐ NO

IF YES, WHAT IS YOUR TOTAL HOSPITAL BILL? ____________________

AND WHAT WAS YOUR MONTHLY PAYMENT? ____________________

LEGAL CLAIM INFORMATION:

ARE YOU/SPOUSE CURRENTLY INVOLVED IN A LAW SUIT? ❑ YES ❑ NO

IF YES, BRIEFLY EXPLAIN: ______________________________

ATTORNEY'S NAME ADDRESS AND PHONE NUMBER HANDLING THE LAW SUIT: ______________________________

HAVE YOU/SPOUSE EVER BEEN INVOLVED IN A LAW SUIT? ❑ YES ❑ NO

IF YES BRIEFLY EXPLAIN: ______________________________

ATTORNEY'S NAME: ______________________________ PHONE: ______________

SETTLEMENT DATE, AMOUNT AND TERMS: ______________________________

ATTORNEY'S NAME: ______________________________ PHONE: ______________

HAVE YOU EVER FILED A WORKMAN'S COMP. CLAIM? ❑ YES ❑ NO

IF YES, WHO IS THE CLAIM WITH AND WHAT WERE THE AMOUNTS AND TERMS OF THE SETTLEMENT? ______________

EMPLOYMENT INFORMATION:

APPLICANTS EMPLOYER: ______________________________

ADDRESS: ______________________________ PHONE: ______________

HOURLY PAY RATE: ______________________________ HOURS PER WEEK: __________

WHEN DID YOU START WORKING HERE? ______________________________

PREVIOUS EMPLOYER: ______________________________

ADDRESS: ______________________________ PHONE: __________

HOURLY PAY RATE: ______________________________ HOURS PER WEEK: __________

START AND END DATE: ______________________________

OTHER SOURCES OF INCOME AND AMOUNTS: ______________________________

____

____

Registered @ SD Dept. of Labor? ☐ YES ☐ NO

SPOUSE/SIGNIFICANT OTHER:

EMPLOYER: ______________________________

ADDRESS: ______________________________ PHONE: __________

HOURLY RATE: ______________________________ HOURS PER WEEK: __________

WHEN DID YOU START WORKING HERE? ______________________________

PREVIOUS EMPLOYER: ______________________________

ADDRESS: ______________________________ PHONE: __________

HOURLY RATE: ______________________________ HOURS PER WEEK: __________

START AND END DATE: ______________________________

OTHER SOURCES OF INCOME AND AMOUNTS: ______________________________

____

____

Registered @ SD Dept. of Labor? ☐ YES ☐ NO

FINANCIAL ASSETS AND RESOURCE INFORMATION:

HAVE YOU/SPOUSE BEEN THE BENEFICIARY OF AN INHERITANCE? ☐ YES ☐ NO

IF YES, AMOUNT AND DATE: ______________________________

DO YOU/SPOUSE HAVE ANTICIPATED INCOME FROM OUTSTANDING LOANS YOU HAVE GIVEN? ☐ YES ☐ NO

IF YES, STATE THE AMOUNT AND REPAYMENT SCHEDULE: ______________________________

HAVE YOU/SPOUSE RECEIVED OR ANTICIPATE TO RECEIVE AN IRS TAX REFUND? ☐ YES ☐ NO

IF YES, AMOUNT: ______________________________

HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY BENEFITS? ☐ YES ☐ NO

IF YES, DATE FIRST APPLIED: ______________________________

HAVE YOU EVER RECEIVED A LUMP SUM FROM SOCIAL SECURITY FOR RETROACTIVE PAY? ☐ YES ☐ NO

IF YES, HOW MUCH RECEIVED AND DATE RECEIVED: ______________________________

ARE YOU IN AN APPEAL PROCESS WITH SOCIAL SECURITY FOR DISABILITY BENEFITS? ☐ YES ☐ NO

IF YES, HOW MANY APPEALS HAVE YOU MADE? ______________________________

HAVE YOU GONE BEFORE THE JUDGE WITH YOUR APPEAL? ______________________________

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, HOW MUCH DO YOU RECEIVE AND THE TIME FRAME IT COVERS? ______________________________

DO YOU/SPOUSE HAVE ANY OF THE FOLLOWING? PLEASE INCLUDE THE AMOUNTS, ACCOUNT NUMBERS, NAME OF BANK, CREDIT UNION, ETC.

TYPE:	**AMOUNT**	**ACCOUNT NUMBER**	**BANK, CREDIT UNION, ETC.**
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/SPOUSE JOINTLY ON AN ACCOUNT WITH ANOTHER INDIVIDUAL? ☐ YES ☐ NO

IF YES, NAME AND ACCOUNT NUMBER AND DESCRIPTION: ____________________

____

____

EQUITY VALUE OF HOUSEHOLD AND PROPERTY

TYPE	EQUITY	PAYOFF
HOUSE/REAL ESTATE:	____________	____________
VEHICLES:	____________	____________
	____________	____________
RECREATIONAL VEHICLES:	____________	____________
OTHER:	____________	____________
BUSINESS PROPERTY:	____________	____________

DO YOU/SPOUSE CURRENTLY OR HAVE YOU EVER OWNED A BUSINESS? ☐ YES ☐ NO

IF YES, NAME, LOCATION, DATE: ____________________

____

____

EQUITY VALUE OF EQUIPMENT, PROPERTY AND INVENTORY: ____________________

____

____

ARE YOU/SPOUSE CURRENTLY A PARTNER/SILENT PARTNER IN A BUSINESS? YES NO

IF YES, NAME, LOCATION: ____________________

____

HAVE YOU/SPOUSE RECENTLY SOLD OR TRANSFERRED ANY PROPERTY 36 MONTHS PRIOR TO ONSET OF ILLNESS? BRIEFLY EXPLAIN: _

____

ARE YOU/SPOUSE INVOLVED IN A CONTRACT FOR DEED OR LEASE SITUATION EITHER AS A SELLER OR BUYER?

____

____

INSURANCE INFORMATION:

DO YOU HAVE A LIFE INSURANCE POLICY? ______________________________

WHOLE/TERM ______________________________ AMOUNT:______________

BENEFICIARIES: ______________________________

____

____

____

____

HAVE YOU/SPOUSE APPLIED OR BEEN TURNED DOWN FOR HEALTH INSURANCE **(INCLUDING THROUGH THE AFFORDABLE CARE ACT)** IN THE PAST 12 MONTHS? ☐ YES ☐ NO

IF YES, WHY? (VERIFICATION REQUIRED) ______________________________

____

HAVE YOU/SPOUSE EVER BEEN ELIGIBLE FOR COBRA INSURANCE? ☐ YES ☐ NO

IF YES, WHAT IS/WAS THE PREMIUM AMOUNT ______________________________

DID YOU EVER REFUSE COBRA PLAN? ☐ YES ☐ NO

IF YES, WHEN?______________________________

IS HEALTH INSURANCE OFFERED THROUGH YOUR /SPOUSES EMPLOYMENT? ☐ YES ☐ NO

IF YES, MONTHLY PREMIUM AMOUNT ______________________________

WERE YOU A COLLEGE STUDENT DURING TIME OF ILLNESS/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? ______________________________

____

I, THE UNDERSIGNED APPLICANT OR REPRESENTATIVE, 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 28-14-7, A LIEN WILL BE FILED AGAINST ME AND ANY PERSONAL PROPERTY OR REAL ESTATE THAT I NOW OWN OR HAVE ANY LEGAL INTEREST IN, OR MAY OWN IN THE FUTURE, FOR ANY ASSISTANCE GIVEN ME BY BEADLE COUNTY. I FURTHER UNDERSTAND THAT I AM REQUIRED BY LAW TO MAKE REPAYMENTS TO BEADLE COUNTY FOR ASSISTANCE GIVEN. SHOULD THERE BE NO ACTION MADE ON REPAYING THIS LIEN, IT WILL BE SUBJECT TO COLLECTION.

APPLICANT:____DATE________________

SPOUSE: ____DATE________________