

Date	Last Name	IC	New	Case #
------	-----------	----	-----	--------

For office use only

Application for County Assistance

Primary language	Do you need an Interpreter? Y N
------------------	---------------------------------

Please check the type of assistance you are requesting:

- Rent
 Deposit
 Utility
 Medication
 Food
 Bus Passes
 ID
 Dental
 Medical
 COBRA
 Other

Please list ALL household members, starting with you:

FULL NAME: first, middle, last include maiden name	Relationship to Applicant	Sex	Race	Education	Current School	Birth Date & Birth Place	SS #
	Self			Last grade completed ____ Degree Y N			
			Tribal affiliation Y N	Last grade completed ____ Degree Y N			
				Last grade completed ____			
				Last grade completed ____			
				Last grade completed ____			
				Last grade completed ____			

Current Street Address			Apt #	City		County	Zip
Date moved in	Rent \$	Deposit \$	Lot Rent \$	Mortgage \$	#Bedrooms	Home Phone	
	Subsidized Y N			Loan #		Cell Message	
Landlord/Mortgagor			Landlord Address			Landlord Phone	

Which utilities do you pay? Gas
 Propane
 Electric
 Water/Sewer
 Garbage
 Phone
 Cell phone
 Cable
 Internet

MARITAL STATUS
 Single (never been married)
 Married
 Separated
 Divorced
 Widow(er)

Married To	Date	City	State
Divorced From	Date		
Separated From	Date		

CITIZENSHIP STATUS US Citizen Eligible Non-Citizen Ineligible Non-Citizen

If not a US Citizen, Alien # & Entry Date (into the United States) is required. Alien # _____ Entry Date: ____/____/____

HOUSING HISTORY & BARRIERS

Previous Address	Rent \$	Date Left	Reason for Leaving
------------------	---------	-----------	--------------------

Are you currently homeless? Includes living with friends/relatives.	Y N	Date you became homeless:
Have you ever been evicted/asked to leave a residence you rented or owned?	Y N	Date: Reason:
Have you ever been evicted/asked to leave any Housing Programs including Heartland House, St. Francis House, Dakota/Lakota House, Section 8 or HUD?	Y N	Date:
Are you or any member of your household a registered sex offender in any state?	Y N	State:
Have you/anyone in the home been convicted of a violent or drug related crime or a felony?	Y N	Date of conviction:
Are you currently on the Sioux Falls Housing waiting list?	Y N	Date applied:

FAMILY

Note: Your nearest relative may live in another state.

Parents Names (if living)	Address	Employer	Able to provide assistance? Please explain.
Spouse's Parents (if living)			
Nearest Relative's Name			
Spouse's Nearest Relative			

CHILD SUPPORT

Child Support Orders	Child's Name	Parent's Names	Address	Employer
Current child support order? Y N Amount of the order \$				
Current child support order? Y N Amount of the order \$				

MILITARY SERVICE (all branches including National Guard & Reserves)

NO VETERANS IN THE HOME

Service Member's Name	Branch	Dates	Discharge Type
------------------------------	---------------	--------------	-----------------------

Applied for VA Medical Services? Y N	Outcome?	Applied for VA Housing Programs? Y N	Outcome?
---	-----------------	---	-----------------

HEALTH & INSURANCE

Name	Health Diagnosis	Medication(s)	Medication out of pocket cost per mo	Pharmacy	Medical Insurance Provider	Insurance out of pocket cost per mo
Self					Medicaid Y N Other:	
					Medicaid Y N Other:	
					Medicaid Y N Other:	

If no insurance but you take medications, have you applied for any prescription assistance programs? Y N

EMPLOYMENT: List current and previous employment information for **everyone** in the home

Name	Employer	Start Date	End Date	Job Title	Wages	Hours per week	Why Left
Self	Current						
	Previous						
	Previous						
	Current						
	Previous						
	Previous						

VEHICLE(S)

Year	Make/Model	Date of Purchase	Payment Per Month	Balance Owed \$	Value \$	Owner's Name

INCOME/ASSETS (not previously listed)

Income Type	Amount	Assets	Value/Amount
SSDI		HOME	
SSI		BUSINESS	
SS		LAND	
SNAPS (FOOD STAMPS)		VEHICLE(S)	
TANF		TAX REFUND	
CHILD SUPPORT		SAVINGS ACCOUNT	
RENT or UTILITY assistance within the last year	Y N \$	Bank:	
CHILDCARE ASSISTANCE	Y N	CHECKING ACCOUNT	
ENERGY ASSISTANCE (LIEAP)	Y N \$	Bank:	
UNEMPLOYMENT		STOCKS/BONDS	
WORKER'S COMP.		CDs/IRAs	
VETERAN'S BENEFITS		INHERITANCE/TRUSTS	
RETIREMENT		401 K PLAN	
RENTAL/LAND INCOME		LAND OWNED	
WIC	Y N	STUDENT LOANS	
UTILITY CHECK		LIFE/BURIAL POLICY	
ALIMONY		BELONGINGS SOLD	
OTHER		OTHER	

EXPENSES (not previously listed)

Monthly Expenses	Amount you pay per month
CAR INSURANCE	
RENTER'S INSURANCE	
LIFE INSURANCE	
CHILDCARE	
PAYDAY LOANS	
TITLE LOANS	
MEDICAL BILLS	
CHILD SUPPORT	
WAGE GARNISHMENTS	
CREDIT CARDS	
LEGAL (fines, restitution etc)	
STUDENT LOANS	
PAWN TICKETS	
RENT-TO-OWN ITEMS	
GASOLINE	
FOOD (above what food stamps covers)	
HYGIENE/CLEANING ITEMS	
OTHER	

I DECLARE AND AFFIRM, UNDER THE PENALTIES OF PERJURY AND DENIAL OF BENEFITS, THAT THE ABOVE INFORMATION GIVEN IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND CORRECT.

SIGNATURE _____ DATE _____

**Part 1 AUTHORIZATION FOR
RELEASE OF INFORMATION**

Birth Date _____

SS# Number _____

Street Address or RFD

City, State & Zip Code

I, _____, being an applicant or client for financial assistance from Minnehaha/Lincoln County Department of Human Services and in order for them to develop an adequate record and file pertaining to my eligibility and suitability to qualify for services under the laws, rules, regulations and procedures of such agency, hereby authorize any individual or agency of any nature to release and furnish to the Minnehaha/Lincoln County Department of Human Services any information they have in their files regarding my physical, mental, academic, psychological, drug or alcohol abuse, social and economic condition. This information will be considered confidential information and shared only with institutions and agencies assisting with my financial needs.

This authorization shall be in effect for one year from this date, unless revoked by in writing at any time, except to the extent that action has already been taken to comply with it.

A copy of this release shall be as valid as the original.

Client's Signature _____ Date _____

Spouse's Signature _____ Date _____

Caseworker/Witness _____ Date _____

PART II REQUEST FOR INFORMATION PHONE: 605-367-4217 FAX: 605-367-4235

Return to _____
Minnehaha/Lincoln County Caseworker

Minnehaha/Lincoln County Department of Human Services
521 North Main Avenue, Suite 201
Sioux Falls, SD 57104-5965

1. ELIGIBILITY QUALIFICATIONS

A. Eligibility for county welfare assistance is based on several factors including:

- a. income, including current, past and/or future;
- b. value of personal and real property and other assets;
- c. the number of household members;
- d. proof of Minnehaha or Lincoln County residency;
- e. proof of identification;

B. After you have completed an application for county welfare assistance, you will receive written notice of eligibility within five business days.

II. APPLICANT'S RESPONSIBILITIES

A. Each applicant has the responsibility to accurately report all facts necessary to the determination of eligibility, all sources of income, any other assistance received, the number of household members, all savings and checking accounts, the value of any personal or real property and other assets.

B. Every client must report all changes in facts listed in II above.

C. Applicants must seek out other sources of assistance within one week of applying for county assistance.

III. CLIENT'S RIGHTS

A. If you are not satisfied by the decision made by Minnehaha or Lincoln County Human Services, you have the right to a review by the County Director or his designee.

B. If you are dissatisfied by the decision made by the County Human Services Director or designee, you may petition directly to the County Commission by filing a notice at the County Auditor's office within 10 business days of the issuance of the Notice of Adverse Action from the County Director or his designee.

IV. CASEWORKER'S RESPONSIBILITIES

A. Caseworkers have the responsibility to investigate and verify all statements made at the time of application and thereafter. The investigation may occur at the time of application, while receiving assistance, or after assistance has been received.

B. Caseworkers must explain other possible resources to the applicant.

C. Caseworkers only supplement other forms of assistance in extreme emergencies and only when all other resources have been exhausted.

V. LIEN/BILL

A. When Minnehaha or Lincoln County Human Services assistance has been provided to a person, the County has a claim against that person for the value of such assistance. That bill may be enforced as a lien against any property which the recipient and the recipient’s spouse may have at that time or later acquire. This lien remains in effect until paid in full or compromised with the County Commission. This bill follows the person and property owned anywhere.

B. Minnehaha County liens may be paid off in full or in partial payments either at the Human Services Office: 521 North Main Avenue, Suite 201, Sioux Falls, SD 57104 or at the Treasurer’s Office. Lincoln County liens may be paid off in full or in partial payments at the Lincoln County Auditor’s Office: 104 N Main Ave. Ste. 110, Canton, SD 57013. A receipt for the amount paid will be issued to the person upon request.

C. The County may send your bill/lien to a collection agency if it is not paid.

VI. WORK RELIEF

In all cases where assistance is requested, the applicant may be required to perform labor or other services of a public nature equal to the amount of aid granted by the Minnehaha or Lincoln County Human Services Office.

VII. REASONS FOR DISQUALIFICATION

A. Any person may be denied or terminated from assistance who, by means of an intentionally false statement, misrepresentation, impersonation, or other willfully fraudulent act or device, obtains or attempts to obtain any assistance otherwise merited.

B. Failure of the applicant to responsibly perform the duties set forth in VI above may be grounds for denial or termination of assistance.

I have read the rights and responsibilities that are mine under the County Human Services Program. Questions that I have concerning these rights and responsibilities have been fully explained to me. I understand and accept my rights and responsibilities under this program as set forth in state law and referenced above.

NAME **DATE** **NAME** **DATE**

CASEWORKER NAME **DATE**

The Minnehaha/Lincoln County Human Services Offices shall not discriminate on the basis of race, color, creed, religion, sex, ancestry, national origin, handicap, marital status or affectionate preference when granting assistance.