

HOW DO I APPLY FOR NON-MEDICAL ASSISTANCE?

STEP 1:

You must file an application for assistance on an approved application form. Applications will not be taken over the phone and only applications submitted on the approved application form will be considered. Once you have completed your application, you must submit your application to Twin Falls County Social Services department.

STEP 2:

When you have completed your application, Twin Falls County Social Services department will schedule an interview with a caseworker.

STEP 3:

At the time of your scheduled interview, you will be required to submit all supporting documents pertaining to your income and household expenses. The caseworker will then prepare and present your case to the Twin Falls County Commissioners. The County Commissioners will determine if the case is approved or denied. Failure to submit required documentation may result in a denial by the County Commissioners.

STEP 4:

A letter of determination will be sent to you at the address on file.

INTERVIEW LOCATION: Twin Falls County Social Service office located at 630 Addison Avenue West, Suite 2100, 2nd floor Twin Falls, Idaho 83301

Please arrive 10 minutes prior to your appointment and plan for a 1 hour interview. If you need to reschedule your appointment, please call our receptionist at 208-736-4037 at least 24 hours prior to your appointment. Your appointment will NOT be rescheduled a third time. Failure to keep your appointment or failure to cooperate with our investigation will result in a denial of your application.

REQUIRED INFORMATION FOR COUNTY SOCIAL SERVICES INTERVIEWS

The following information is required when applying for County Social Services. You must provide the relevant information where applicable for household members to the County Social Services Office at the time of your interview. You can email the information to indigent@tfco.org.

1. Photo ID of applicant and any other adults in the household;
2. Social Security cards, temporary resident/alien resident card, work/student visas for all household members;
3. Proof of residency;
4. Verification of all household income for the past three (3) months, such as wage stubs, cash settlements, Social Security, welfare, interest, retirement, rent escrow, veteran's benefits, workers compensation, other income in the form of financial aid award letters, and written statements from those who give or loan you money;
5. If self-employed, year to date profit and loss statements for business;
6. Completed federal and state tax returns for the most recent year;
7. Last three (3) months bank statements for all checking and savings accounts;
8. Written proof of value of all assets such as IRAs, certificates of deposit (CDs), stocks, bonds, real estate (buying/owned), motor vehicles, recreation vehicles, trailers, farm equipment, livestock, timber or mining claims, and other items of value;
9. Life, health and burial insurance policies;
10. Proof of all monthly household expenses and all outstanding debts including rent, mortgage, utilities, insurance, transportation, credit card payments, child support, child care, fines, taxes, medication and other medical payments. The documentation should include balance due and monthly balances. Proof of payment must be provided; and
11. Any other information requested by the County Assistance office.

CHILD CARE ARRANGMENTS MUST BE MADE PRIOR TO THE INTERVIEW.

IF NEEDED, AN INTERPRETER WILL BE PROVIDED TO YOU AT THE TIME OF THE INTERVIEW.

Date Received:

TWIN FALLS COUNTY ASSISTANCE APPLICATION

| | | | |
|--|------|-----------|----------------------------------|
| Do you need an interpreter: Yes No | | | |
| If yes, what language: | | | |
| TYPE OF ASSISTANCE REQUESTED | | | |
| LANDLORD/AGENCY TO BE PAID | | | |
| Name: | | | |
| Address: | | City: | State: Zip: |
| Telephone: | | Email: | |
| Type of Service (circle one): | Rent | Utilities | Cremation/Burial |
| Dates of Service: | | | |
| Amount Requested: | | | |
| | | | |

| PERSONAL INFORMATION | | | | | |
|---------------------------------------|----------------|------------|--------------------------|-------------------|----------|
| First Name | Middle Initial | Last Name | Date of Birth | Social Security # | |
| Other names used: | | | | | |
| Physical Address | | City | State | Zip | County |
| Mailing Address (if different) | | City | State | Zip | County |
| Phone Number: | | | Email address: | | |
| Marital Status (circle one): | | Married | Single | Widowed | Divorced |
| Citizenship (circle one): | | US Citizen | Legal Permanent Resident | Other | |
| Valid Permanent Resident Card Number: | | | | | |
| Veteran (circle one): | | Yes | No | | |
| If yes, type of discharge: | | | | | |
| Registered to Vote (circle one): | | Yes | No | | |
| If yes, what county: | | | | | |
| Licensed to drive: | | Yes | No | | |
| If yes, what state: | | | | | |
| | | | | | |
| SPOUSE/SIGNIFICANT OTHER | | | | | |
| First Name | Middle Initial | Last Name | Date of Birth | Social Security # | |
| Other names used: | | | | | |
| Physical Address | | City | State | Zip | County |
| Mailing Address (if different) | | City | State | Zip | County |
| Phone Number: | | | Email address: | | |
| Marital Status (circle one): | | Married | Single | Widowed | Divorced |
| Citizenship (circle one): | | US Citizen | Legal Permanent Resident | Other | |
| Valid Permanent Resident Card Number: | | | | | |
| Veteran (circle one): | | Yes | No | | |
| If yes, type of discharge: | | | | | |
| Registered to Vote (circle one): | | Yes | No | | |
| If yes, what county: | | | | | |
| Licensed to drive: | | Yes | No | | |
| If yes, what state: | | | | | |

HOUSEHOLD

Complete the following information for all persons residing in your home.

Attach additional pages if needed.

| Name | Sex | Relationship to Applicant | Date of Birth | Social Security # |
|------|-----|---------------------------|---------------|-------------------|
| | | | | |
| | | | | |
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OTHER ASSISTANCE - Circle response for each

1. Is anyone in your household covered by Medicaid? Yes No

2. Is anyone in your household an enrolled member of a Native American Tribe: Yes No

If Yes, who: _____ Name of Tribe: _____

Phone number of tribal Council/BIA offices for this Tribe: _____

3. Have you or anyone in your household ever been disqualified from an assistance program? Yes No

If Yes, list names of persons disqualified from assistance program: _____

4. Do you or anyone in your household have actions pending from which money may be received such as lawsuits, inheritance, accident claim, insurance settlement, etc? Yes No

5. Have you or anyone in your household ever been approved for county assistance in Idaho? Yes No

6. Have you or anyone in your household applied for Medicaid, SSI or Crime Victims in the past year? Yes No

If Yes, name of program and date filed: _____

RESIDENCY: Please list your place of residence for the last 5 years. Attach additional pages if needed.

| Physical Address | Dates of Residence | Landlord |
|---|--------------------------|-------------------------------|
| Street: _____ City: _____ State: _____ | From: _____ To: _____ | Name: _____ Phone #: _____ |
| Street: _____ City: _____ State: _____ | From: _____ To: _____ | Name: _____ Phone #: _____ |
| Street: _____ City: _____ State: _____ | From: _____ To: _____ | Name: _____ Phone #: _____ |
| Street: _____ City: _____ State: _____ | From: _____ To: _____ | Name: _____ Phone #: _____ |

| | | | | |
|---|-------------------------|--------------------|--------------|-----|
| EARNED INCOME: Employment information (Attach additional pages if needed): | | | | |
| APPLICANT | | | | |
| Current Employer: | Address | City | State | Zip |
| Hours per Week: _____ | Dates of Employment: | | Phone: _____ | |
| Hourly Rate: _____ | From: _____ | | _____ | |
| Monthly Gross: _____ | To: _____ | | _____ | |
| APPLICANT | | | | |
| Current/Past Employer: | Address | City | State | Zip |
| Hours per Week: _____ | Dates of Employment: | | Phone: _____ | |
| Hourly Rate: _____ | From: _____ | | _____ | |
| Monthly Gross: _____ | To: _____ | | _____ | |
| SPOUSE/SIGNIFICANT OTHER | | | | |
| Current Employer: | Address | City | State | Zip |
| Hours per Week: _____ | Dates of Employment: | | Phone: _____ | |
| Hourly Rate: _____ | From: _____ | | _____ | |
| Monthly Gross: _____ | To: _____ | | _____ | |
| SPOUSE/SIGNIFICANT OTHER | | | | |
| Current/Past Employer: | Address | City | State | Zip |
| Hours per Week: _____ | Dates of Employment: | | Phone: _____ | |
| Hourly Rate: _____ | From: _____ | | _____ | |
| Monthly Gross: _____ | To: _____ | | _____ | |
| UNEARNED INCOME | | | | |
| Are you or anyone in your household receiving income from any of the following sources: Circle any source of income. | | | | |
| Social Security | Child Support/Alimony | Church | | |
| SSI | Worker's Compensation | Energy Assistance | | |
| Tribal/BIA | Insurance Settlements | SNAP Benefits | | |
| Interest/Dividends | State Cash Assistance | Veteran's Benefits | | |
| Rental/Escrow | Inheritance/Trust | Retirement | | |
| Income Tax Refund | Unemployment | Gifts/Loans | | |
| Community Organization | Other | | | |
| If you circled any of the above, please complete the information below. | | | | |
| Source of Unearned Income | Person Receiving Income | Amount Received | | |
| | | | | |
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FINANCIAL ASSETS

Complete the following information regarding any items that you or your spouse/significant other own, or on which either of your names appear.

| Description | Name(s) on Account | Institution Name | Amount/Value |
|------------------|--------------------|------------------|--------------|
| Cash | | | |
| Checking Acct. | | | |
| Other Checking | | | |
| Line of Credit | | | |
| Savings Acct. | | | |
| CD | | | |
| Stocks/Bonds | | | |
| Mutual Funds | | | |
| Trusts/Annuities | | | |
| Retirement | | | |
| Credit Cards | | | |
| Other | | | |

REAL PERSONAL PROPERTY

| Property | Description | Market Value | Amount Owed | Equity |
|----------------------------------|-------------|--------------|-------------|--------|
| Home Residence | | | | |
| Manufactured Home | | | | |
| Year/Make/Model | | | | |
| Land | | | | |
| Rental Property | | | | |
| Vehicle | | | | |
| Is it Licensed | Yes | No | | |
| Used for business | Yes | No | | |
| Recreation Vehicle/Trailer/Other | | | | |
| Livestock | | | | |
| Items of Trade | | | | |
| Pending Claims | | | | |
| Burial Plots | | | | |
| Life Insurance | | | | |
| Other | | | | |

Have your or your spouse/significant other sold, traded, given away or put into a trust money or any resources within the last year? If you have, complete the information below.

| Description | Where Sold | Amount Received |
|-------------|------------|-----------------|
| | | |
| | | |
| | | |

| MONTHLY EXPENSES | | | | |
|---|--------------------|----------------|----------|-------------|
| Description | | Monthly Amount | Past Due | Balance Due |
| Rent | | | | |
| Subsidized: Yes No | | | | |
| Space Rent | | | | |
| To: | | | | |
| Food - allowable amount per USDA Thrifty Food Plan | | | | |
| Non-Food - allowable amount preset at \$65 per person in home | | | | |
| Utilities: Bills required | Heat | | | |
| | Electricity | | | |
| | Water | | | |
| | Sewer | | | |
| | Telephone | | | |
| | Internet | | | |
| Insurance: Proof of payment required | Health/Accident | | | |
| | Home/Renters | | | |
| | Life | | | |
| | Auto | | | |
| Transportation: | Car Payment to: | | | |
| | Fuel | | | |
| | Maintenance | | | |
| | Alternate | | | |
| Medical: Proof of payment required | Doctor | | | |
| | Hospital | | | |
| | Medications | | | |
| | Other | | | |
| Taxes: | Payroll | | | |
| | Property | | | |
| Educational Expenses: Proof of payment required | | | | |
| Child Care: | Subsidized: Yes No | | | |
| Dues & Tithing: Proof of payment required | | | | |
| Court Ordered: Proof of payment required | Child Support | | | |
| | Garnishments | | | |
| | Fines | | | |
| Contract/Credit Card payment: proof of payment required | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |

RELEASE OF INFORMATION NON-MEDICAL COUNTY ASSISTANCE

In order to cooperate fully with the investigation and determination of my application for county non-medical assistance, I hereby authorize representatives from Twin Falls County Assistance Department to discuss my application with and to secure information, data, copies and records from my relatives, bankers, credit unions, physicians, hospitals, creditors and any other persons or organizations including, but not limited to the State Department of Health and Welfare, Social Security Administration, all branches of the United States Military, Tribal Records, law enforcement agencies, courts, Idaho Department of Labor or employers having any information concerning me or my circumstances that said county representative feels is pertinent to the investigation of my application

I hereby authorize Twin Falls County to release and exchange pertinent information regarding this application, the contents thereof and action taken thereof with all parties of interest, including but not limited to those listed herein. I acknowledge that my application for assistance waives any and all confidentiality granted by state or federal law to the extent necessary to carry out the intent of Idaho Code Title 31, Chapter 34 regarding my application. I hereby authorize a copy of this agreement to be used when necessary and give it full force as the original.

I understand that I may revoke this consent at any time by submitting to the Twin Falls County Assistance Department a written document signed by me and notarized except to the extent that action has been taken in reliance on it, and that unless consent is sooner revoked, this release is valid as long as it is pertinent to this application. I also understand that if I revoke this consent, to the extent it prevents or substantially interferes with the completion of the investigation of my application, it may result in my application being denied. **I understand that by accepting assistance from the county, I agree to repay the county for all or any portion of expenses paid on my behalf as determined by the Board of County Commissioners.**

I certify under penalty of perjury pursuant to the law of the State of Idaho that the information contained in my application for county assistance is true and correct to the best of my knowledge.

Signature of Applicant

Signature of Spouse/Significant Other

Date: _____

Date: _____

Printed Name

Printed Name