Agency Use Only
____ Recipient
____ New Applicant

COUNTY BURIAL APPLICATION

Wright County Health & Human Services

Full Name of Deceased: _____

Last Address: _____

Date of Death: _____ Date of Birth: _____ SS# : _____

Marital Status: _____ Cause of Death (if known): _____

List Immediate Family Members (Spouse, Children, Parents):

Name	Relationship	Address

Income: (list type and amount of income received by the deceased and surviving spouse or parent(s). If income is from wages, please list any unpaid wages due the deceased along with the name/address) of employer.

_____ $ _____
_____ $ _____
_____ $ _____

ASSETS:

Checking Account: $ _____ Bank Name/Location: _____

Savings Account: $ _____ Bank Name/Location: _____

Nursing Home Trust Account: $ _____ Location: _____

Prepaid Burial: $ _____ Bank Name/Location: _____

Burial Plot: $ _____ Yes ☐ If yes where? _____ No ☐

Life Insurance: Yes ☐ Value: $ _____ Beneficiary: _____ No ☐

Motor Vehicles: Yes ☐ Type/Year/Model: _____ No ☐

Real Estate: Yes ☐ Address of Property: _____ No ☐

Mobile Home: Yes ☐ Year/Make/Location: _____ No ☐

Other (CD's, Stocks, Bonds, Boats, Campers, Snowmobiles, Motorcycles, etc.): _____

Has the decedent transferred or given away any cash, property, etc. within the past 60 months?

Yes ☐ Describe: _____ No ☐

Was the deceased a Veteran? **Yes** ☐ **No**

Is the cause of death related (directly or indirectly) to an injury or condition received while in active military status? Yes ☐ No ☐

Are any relatives able to help pay for this funeral? _____ If yes, how much? $ _____

FUNERAL SERVICES REQUESTED:

Funeral Home: _____

Address: _____ Phone: _____

Professional Services/Casket/Vault Lining	Yes ☐	No ☐
Opening/Closing of grave	Yes ☐	No ☐
Lot	Yes ☐	No ☐
Cremation	Yes ☐	No ☐

Cash advance items such as flowers, grave marker, obituary notices, motor escort, clergy fees, death certificates, etc. are not covered; relatives may provide for these items. Memorial money collected may be used for these items.

I certify that this information is true and accurate to the best of my knowledge. I understand that if there are assets or remaining income, this may need to be applied toward the cost of burial. The Fiscal Technology Unit of Wright County Health & Human Services will ask that this be turned over to the county.

_____ _____

Signature Relationship to deceased

_____ _____

Name (print) Date

_____ _____

Address Phone

For Agency Use Only Case No: _____

Wright County Financially Responsible? Yes ☐ No ☐ PMI No: _____

$ _____ Amount Approved for County Burial

☐ Approved

Breakdown: $ _____ Burial /Cremation Services

$ _____ Opening/Closing of gravesite

☐ Denied $ _____ Burial Plot

$ _____ Other : _____

Comments: _____

_____

_____

_____ _____

Worker's Signature Date

☐ Cc to Collection Officer ☐ Notice sent to family ☐ Case note in MAXIS

Please mail or fax to:

Financial Services Supervisor
Wright County Health & Human Services
10 – 2nd Street NW Room 300
Buffalo, MN 55313
FAX # 763-682-8920

Jami Goodrum Schwartz
Director

WRIGHT COUNTY HEALTH & HUMAN SERVICES

www.co.wright.mn.us

Administration · Fiscal Technology & Support
Social Services · Public Health
1004 Commercial Drive, Buffalo, MN 55313 – Phone: 763-682-7400

Financial Services · Child Support
10 2nd Street NW, Room 300, Buffalo, MN 55313 – Phone: 763-682-7414

General Authorization for Release of Information

Date: _____

To: _____
_____
_____

Case Number: _____

Agency Rep Name: _____

Agency Phone Number: _____

Agency Name: **Wright County Health & Human Services**

Agency Address: **10 2nd St. NW, Room 300**

City, State, Zip: **Buffalo, MN 55313-1191**

We need to verify the following information about the person(s) listed below:

Name:	**SSN:**
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

Please provide the information requested. **Attach verification documents *or* record the information on the back of this form and sign where indicated.** Return the form to the requesting agency. On the bottom half of this form is a signed authorization to release information to the human services agency listed above.
Thank you for your cooperation.

Authorization for Release of Information

Giving Permission: I give permission for the business/ organization above to release the requested information to the above agency. This information will be used to determine eligibility for public assistance and/or services.
Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information.
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- That, generally, I must give my written consent for this agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it.
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested.
- The person or agency that gets my information may be able to pass it on to others.

This authorization will end one year from the date that I sign it, unless the law allows for a longer period.

Client Signature:	Date:	Original copy for agency Provide copy to client
Signature of Spouse/Guardian/Authorized Representative:	Date:	