 UNITED KEETOOWAH BAND OF CHEROKEE INDIANS IN OKLAHOMA

 **Department of Health and Human Services**

 P.O. Box 746, Tahlequah, OK 74465

 18263 W. Keetoowah Circle, Tahlequah, OK 74464

 Phone: 918-871-2830 Fax: 918-414-4030

 **APPLICATION FOR HUMAN SERVICE ASSISTANCE**

 (Application must be completed, and all documentation attached for assistance to be determined)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date UKB District UKB Roll Number**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Name Middle Name Last Name Maiden Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address Physical Address**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City, State, Zip City, State, Zip**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone Message Phone Date of Birth**

**LIST NAME OF EVERY PERSON LIVING IN THE HOUSEHOLD**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Sex | Date of Birth  | Social Security Number | Relationship to Head of Household | Tribal Affiliation |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

**Type of Need: □ Heating □Cooling □Utility Payment □Medical □Emergency**

**Other/Explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of Housing: □ Own □ Buying □Renting** Owned by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST NET INCOME OF ALL PERSONS LIVING IN HOUSEHOLD (AGE 18 and above)**

|  |  |  |  |
| --- | --- | --- | --- |
| **SOURCE OF INCOME** | **HEAD OF HOUSEHOLD** | **SPOUSE** | **OTHERS:** |
| **Salary/Wages:** | **$** | **$** | **$** |
| **Unemployment:** | **$** | **$** | **$** |
| **Workmen’s Compensation:** | **$** | **$** | **$** |
| **SSA:** | **$** | **$** | **$** |
| **SSI:** | **$** | **$** | **$** |
| **VA:** | **$** | **$** | **$** |
| **Welfare:** | **$** | **$** | **$** |
| **TANF:** | **$** | **$** | **$** |
| **Food Stamps:** | **$** | **$** | **$** |
| **Child Support:** | **$** | **$** | **$** |
| **Other:**  | **$** | **$** | **$** |

**Does the state pay supplemental insurance/Medicare? Yes No**

**If you said yes, please list name and amount:**

|  |  |
| --- | --- |
| **Name:**  | **Amount:** |
|  |  |
|  |  |

**My TOTAL monthly income from all sources is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you applied for and received services from any other agency or tribe offering LIHEAP?**

**□Yes What Agency/Tribe and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □No**

**CERTIFICATION**

* I/We understand the information in this application is being collected to determine eligibility or assistance operated and provided through the UKB Health and Human Department including LIHEAP, Motor Fuels, and any other Federally Funding program under the UKB HHS Department.
* I/We understand eligibility is based on my/our household income and documentation must be submitted.
* I/We certify the information given in this application is correct to the best of my/our knowledge.
* I/We further understand willing/purposefully giving false statements or false information will cause me/us to be INELIGIBLE for assistance through Federal programs operated by the United Keetoowah Band of Cherokee Indians in Oklahoma Health and Human Services including ­**LIHEAP and any/all Federal Funded Programs** and is also **a criminal offense punishable under Federal Law**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of Household Spouse

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **OFFICE USE ONLY**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application Received by and date: Application reviewed by and date:

Action Taken (include any referrals to outside agency/interdepartmental referrals):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **RELEASE OF INFORMATION**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give permission for any agency involved which I am seeking assistance with (including but not limited to: UKB Departments, other Tribes, DHS, Utility companies (including by not limited to Electric, Natural Gas, Propane, and Water) to release any information required to complete of my application for assistance from the Human Services Department of the United Keetoowah Band. This release is valid for 6 months from date of my signature below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number Phone/Contact Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date



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 These documents are needed to process/complete your application:

1. \_\_\_\_\_\_\_ Income Verification (3 check stubs or disability award letter)
2. \_\_\_\_\_\_\_ Workforce Registration (household members over age 18 and unemployed)
3. \_\_\_\_\_\_\_ DHS Award Letter (Food Stamps, TANF)
4. \_\_\_\_\_\_\_ Invoice/Bill (Requesting assistance to pay)
5. \_\_\_\_\_\_\_ UKB Membership Card
6. \_\_\_\_\_\_\_ Social Security Card for ALL Household Members
7. \_\_\_\_\_\_\_ Address Verification
8. \_\_\_\_\_\_\_ Disaster Situations: Need Fire Marshall or Police Reports
9. \_\_\_\_\_\_\_ Any and All Documents Needed to Support Your Request

 Respectfully,

 Department of Human Services

 United Keetoowah Band of Cherokee Indians

COMMUNITY SERVICES

NO INCOME OR ODD JOB VERIFICATION

**THIS FORM MUST BE NOTORIZED**

**IF YOU HAVE NO INCOME PLEASE COMPLETE THIS SECTION:**

 This statement is to certify that I am not receiving income from any source:

* I am not employed through any public or private employer
* I am not receiving any type of unemployment compensation benefits
* I am not receiving TANF, Social Security Veteran’s Benefits or any other type of benefits.
* I am not receiving a pension, retirement, or any annuity benefits
* I am not receiving child support or any monetary benefits

I understand I must report any changes in income.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**If you do complete odd jobs you must complete this section:**

I do odd jobs and receive $\_\_\_\_\_\_\_\_\_ monthly from these jobs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**This section must be filled out by a notary:**

Subscribed and sworn before me, a Notary Public, on this \_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_, 20\_\_\_\_.

My Commission expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Commission Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Notary

**Warning: Section 1001 of Title 18 of the U.S Code makes it a criminal offense to make willful false states of misrepresentation to any Department of Agency of the U.S to any matter in its jurisdiction.**