



Sac and Fox Nation
Human Services Program
920883 S. Hwy 99, Bldg. A, Stroud, OK 74079
Ph.: 918.968.3526 Fax: 918-968-0142

DOI-Emergency General Assistance
Document Checklist

Name: _____ Date: _____

- _____ DOI-Emergency General Assistance Application
- _____ CDIB/Tribal Enrollment Card(s) for Applicant and their children or Birth certificate if children are not enrolled
- _____ Social Security Card(s) for Applicant and their children
- _____ Driver's License or photo I.D. for Applicant and non-enrolled members over 18 years of age.
- _____ Copy of Bill/Invoice
- _____ Income Verification for everyone over 18 years of age/Check stubs, award letters, etc.
- _____ No income/anyone 18 or older fill out a declaration of income if you have no income
- _____ Resident Verification if bill is not in Applicants name
- _____ Release of Information
- _____ Additional Verification (if needed):

SAC AND FOX NATION
DOI Compact – Human Services
FY 2013
October 1, 2015 – September 30, 2016



PROGRAM GUIDELINES

EMERGENCY GENERAL ASSISTANCE

- Head of Household or spouse (Applicant) must be an enrolled tribal member of a federally recognized tribe.
- Applicant must live within the Sac and Fox Nation jurisdictional boundaries.
- Must be able to document an emergency/crisis that would warrant assistance, including but not limited to, utility cut-off notices, eviction notices, medical illness or fatality, or any other type of emergency where a hardship has been placed on the applicant.
- Payments will be made directly to vendors, up to \$250.00 maximum benefit.
- Household may only receive assistance once per fiscal year.
- Applicant must meet the FY2016 LIHEAP low-income guidelines. If the client is applying for energy assistance, this need must first be met through LIHEAP, if funds are available.
- Documentation verifying each member of the household must be provided, including but not limited to: CDIB cards, Social Security cards, tribal enrollment cards, driver's license, birth certificates, etc.
- Applicant must provide copies of the bills and total household income verifications for every member 18 years of age and older.

SAC AND FOX NATION

HUMAN SERVICES PROGRAM

920883 S. Hwy 99, Bldg. A, Stroud, OK 74079
 Ph: 918.968.3526 FAX: 918.968.0142



APPLICATION FOR DOI-EMERGENCY GENERAL ASSISTANCE

Date: _____

Name: _____ Spouse: _____

Address: _____ Phone (with area code): _____

City: _____ State: _____ Zip: _____

Have you or any member of your household listed below applied for and received DOI – EMERGENCY GENERAL ASSISTANCE in the past twelve (12) months? Yes _____ No _____

LIST ALL HOUSEHOLD MEMBERS: (Include yourself)

	Last Name	First	Date of Birth	Sex	Social Security #	Relationship to Applicant	Tribe & Roll #
1							
2							
3							
4							
5							
6							
7							
8							

-If additional space is needed, attach separate sheet.

INFORMATION: Applicant is applying for assistance with the following: (See attached bill or estimate from vendor)

Utilities: _____ Rent: _____ Medical: _____ Other: _____

DO YOU RECEIVE:

TANF _____ FOOD STAMPS _____ SSI _____ VA _____ NONE _____

SHELTER INFORMATION: OWN _____ RENTED _____ MUTUAL HELP HOME _____

If rented, are utilities included in rent? Yes ___ No ___ if yes, what type? _____
 If included, a statement from landlord must be submitted that states that utilities are included.

INCOME: List income from employment, including self-employment, before deductions for ALL household members. **NOTE: YOU MUST SEND IN COPIES OF CHECK STUBS.**

OTHER INCOME RECEIVED: TANF, SSI, SOCIAL SECURITY, VETERANS BENEFITS, WORKERS COMPENSATION, UNEMPLOYMENT COMPENSATION, CHILD SUPPORT, etc. **NOTE: YOU MUST SUBMIT COPIES OF AWARD LETTERS DATED THIS YEAR.**

Source	Amount	How Often?	Source	Amount	How Often?

LIQUID RESOURCES: Do you or any member of your household have any cash on hand or money in any bank, savings and loan company, credit union, etc: Yes _____ No _____
 If yes, list type, amount, name and location of facility: _____

CLIENT'S STATEMENT OF RIGHTS AND RESPONSIBILITIES:

I hereby authorize the Sac and Fox Nation to make any necessary investigation of my financial situation and other condition relating to my eligibility.

I have the right to a hearing if denied and/or if I feel my application was not acted on in a timely manner. A request for fair hearings must be made in writing to the Business Committee of the Sac and Fox Nation, 920883 S Hwy 99 Bldg A, Stroud, OK 74079 within 10 days.

I have been informed that any person who knowingly, willfully and fraudulently provides false information for the purpose of obtaining benefits which he is ineligible to receive may be subject to prosecution to the fullest extent to the appropriate state or federal stature.

CONFIDENTIALITY: Any information I provide or that is obtained or received on my behalf is considered confidential. I understand all Human Services staff are required to maintain confidentiality of participants unless otherwise noted in the release of information to which I agree.

 Signature of Applicant or Guardian

 Guardian for

 Person assisting with application

 Relationship to applicant

.....
 (For Office Use Only)
 (To be completed by Administrative Assistant)
CERTIFICATION

Income verification reviewed: Yes _____ No _____ If yes, what type: _____

Total monthly household income: _____ Decision: Approved _____ Denied _____

Reason for above decision: _____ Date: _____

Administrative Assistant: _____ Director: _____



DECLARATION OF INCOME
FORM

NAME: _____ CASE #: _____

The size of my household is: _____.

Verification of my income is not currently available and my total household income is \$ _____. I certify that I meet the income guidelines for the _____ assistance program for which I am applying for.

I have been informed that any person who knowingly, willfully, and fraudulently provides false information for the purpose of obtaining benefits which he is ineligible to receive may be subject to prosecution to the fullest extent of the appropriate State or Federal statute.

APPLICANT'S SIGNATURE

DATE

HOUSEHOLD	INCOME
1	\$20,250
2	\$26,481
3	\$32,712
4	\$38,944
5	\$45,175
6	\$51,406
7	\$52,574
8	\$53,742
9	\$54,911
10	\$56,079

NOTE: If any member of an eligible household receives benefits from one of the following sources, the household is considered categorically eligible:

- A. Recipients of TANF (Temporary assistance for needy families) as stated in Sec. 2605 (b) (2).
- B. Persons receiving Food Stamps as stated in Sec. 2605 (b)(2);
- C. Persons receiving SSI benefits as stated in Sec. 2605 (b)(2);
- D. Persons receiving Veterans benefits as stated in Sec. 2605 (b) (2).



Human Services Department

920883 S Hwy. 99 Building A • Stroud, Oklahoma 74079

RELEASE OF INFORMATION

You grant and authorize the exchange of information between the Sac & Fox Nation Human Services Program and the following agencies/programs:

Tribal/State Employment Offices
Tribal/State Social Services Programs
Social Security Administration
Tribal/State Education Programs
Tribal/State/Federal Courts
Tribal/State Medical Services
Tribal Enterprises
Alaska Native Corporations
State/County Fiduciary Trust Offices

Tribal/State Alcohol & Drug Programs
Tribal/State Housing Programs
Veteran's Administration
Tribal/State Federal Probation Programs
Tribal/State Child Protection Services
Tribal/State Mental Health Services
Tribal/State Voc-Rehab Programs
Indian Health Services

Other (specify): _____ other (specify): _____

Any information exchanged will pertain to your eligibility to receive Financial Assistance and Social Service benefits or referral to other programs that would benefit you. By signing on the statement of cooperation (Page 4) you agree and understand any information obtained will be kept confidential and will be used only for the purposes directly connected with providing benefits or services on your behalf. You further agree and understand that any information obtained may be released to proper governmental agency, court, or law enforcement agencies for purposes of legal and investigative action concerning fraud.

This Release of Information will remain in effect for one (1) year from date of signature or until you request to rescind authorization.

I authorize the Human Services Program to obtain and/or exchange information necessary to establish eligibility for Financial Assistance and Social Services.

Name of Applicant (Print)

Date

Signature of Applicant