FORT BELKNAP INDIAN COMMUNITY

FINANCIAL ASSISTANCE REQUEST FORM

CENTRAL ADMINISTRATION
656 Agency Main Street
Harlem, Montana 59526
PHONE: (406) 353-8305
(406) 353-8309
FAX: (406) 353-4541

Please be aware that we are not able to assist you if you are eligible for other programs. All medical requests are to be turned into the Centralized Billing Department. (e.g. If you are getting transported by CHRs or Public Health Nursing, we cannot assist with the cost of fuel for you to drive to your appointment, and we cannot assist you if you are getting help through Medicaid or any other program). Assistance is available to enrolled members who are 60 years or older and shall not exceed $300. Application awarded in six-month intervals.

GENERAL INFORMATION

(Please fill out this application to the best of your knowledge and only skip questions if they do not apply to you)

NAME:_____
LAST FIRST MI

ENROLLMENT NUMBER:_____ **DATE OF BIRTH:**_____
(NOTE: Non-enrolled individuals are NOT eligible for assistance)

MARITAL STATUS:_____ **NUMBER OF CHILDREN UNDERAGE:** _____

ADDRESS:_____
STREET CITY, STATE ZIPCODE

PHONE NUMBER (Home/Cell)_____

APPLICANT QUESTIONAIRE

Are you currently Employed? _____ YES _____ NO

Is your spouse employed? _____YES_____NO

IF yes Who is Your Employer:_____

If Yes, who is your spouse's employer: _____

IF YOU ARE CURRENLY UNEMPLOYED, CIRCLE ANY/ALL ASSISTANCE YOU RECEIVE FROM THE FOLLOWING PROGRAMS:

GENRAL ASSISTANCE **SOCIAL SECURITY** **UNEMPLOYMENT**

FOOD STAMPS **SUPPLIMENTAL SECURITY INCOME (SSI)** **OTHER INCOME**

TANF **(Please Specify): _____**

CHILD SUPPORT

Have you ever received assistance from us before? _____ YES _____NO

If yes, please list the date of last assistance received: _____

REASON YOU ARE REQUESTING ASSISTANCE:
Please include Specific information about why you are requesting assistance (i.e. fuel/meals/lodging for medical appointment, emergency, etc. – include if you will be traveling and to where):

_____
_____
_____
_____

_____

_____

_____

_____

_____

_____

PLEASE ENSURE ALL RELEVANT DOCUMENTATION IS ATTACHED INCLUDING MEDICAL APPOINTMENT SLIP OR OTHER DOCUMENTATION

RECIEPTS MUST BE SUBMITTED FROM ASSISTANCE (TRAVEL – INCLUDING GAS/LODGING/ETC) – OR NO MORE ASSISTANCE WILL BE GRANTED

FILLING OUT THIS APPLICATION **DOES NOT GUARANTEE** APPROVAL. ALL APPLICATIONS WILL BE REVIEWED AND DECIDED ON BASED ON CIRCUMSTANCES AND AVAILABILITY OF FUNDS.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

PLEASE ATTACH ANY DOCUMENTATION WITH REQUEST FORM

OFFICE USE ONLY

Type of Assistance requested (CIRLE OR HIGHLIGHT):

ELDER	EMERGENCY	MEDICAL

Is applicant receiving assistance from Centralized Billing or other Department: _____ YES_____NO
Were receipts received back if prior assistance was received: _____YES _____ NO
Comments:

Approved _____ Denied _____ If Approved, Amount: _____

SIGNATURE: _____ **DATE:**_____