Karuk Community Health Clinic
64236 Second Avenue
Post Office Box 316
Happy Camp, CA 96039
Phone: (530) 493-5257
Fax: (530) 493-5270

Karuk Tribe

Administrative Office
Phone: (530) 493-1600 • Fax: (530) 493-5322
64236 Second Avenue • Post Office Box 1016 • Happy Camp, CA 96039

Karuk Dental Clinic
64236 Second Avenue
Post Office Box 1016
Happy Camp, CA 96039
Phone: (530) 493-2201
Fax: (530) 493-5364

2018-2019 LOW INCOME ASSISTANCE PROGRAM APPLICATION

The applicant must reside within the Karuk tribe's service area (Siskiyou County and Eastern Humboldt County from Bluff creek at mile marker 28.6 to the Siskiyou County line)

Applicant Information:

Name: _____ Gender: ___ Male ___ Female

Physical Address: _____

City_____ State:____ Zipcode _____

Mailing Address: _____

City_____ State:____ Zipcode _____

SSAN: ____/___/____ Date of Birth: ___/___/___ Tel# _____ Cell# _____

Tribal Affiliation: _____ Tribal ID # _____

Are you Handicapped? _____ Are you disabled? _____ Are you a Veteran? _____

HOUSEHOLD/FAMILY COMPOSITION

Household/Family Size _____

Marital Status: **(Circle One)** Single Married Separated Divorce Widowed Significant Other

Household/Family Composition: **(Circle One)**

Single Adult Single-Parent Two-Parent Guardian Multi-Household/Family

List All Other Household Member(s)

Name	Relationship	Date of Birth	Handicapped?	Disabled?
1				
2				
3				
4				
5				
6				
7				

Applicant Income: List all income received in the last month.

1 Name of Employer/Income Source	Monthly Earned Income	Monthly Unearned Income	No Income
1 Name of Employer/Income Source	Monthly Earned Income	Monthly Unearned Income	No Income

Spouse Income: List all income received in the last month.

1 Name of Employer/Income Source	Monthly Earned Income	Monthly Unearned Income	No Income
1 Name of Employer/Income Source	Monthly Earned Income	Monthly Unearned Income	No Income

RECEIVING/PENDING OTHER SERVICES (PLEASE CHECK ALL THAT APPLY)

None (Not Receiving or have any services pending)

	Earned Income	Amount			Unearned Income	Amount
	Wages/Salaries				SSI	
	Alimony/Child Support				SSA	
	Retirement/Pension				County GA	
	Gift/Contributions				County TANF	
	Income Refund (Federal/State)				Tribal TANF	
	Insurance Settlement				Food Stamps	
	Interest/Dividend				Food Commodities	
	Lottery/Gaming Income				LIAP	
	Retirement benefits/Pensions					
	Tribal Per Capita payments					
	Social Security/Survior/disability					
	Unemployment Benefits					
	Veterans Benefits					

REQUIRED DOCUMENTATION

Tribal members applying for LIAP assistance must provide the following information to be determined eligible to receive services from the LIAP program.

DOCUMENT CHECKLIST

	Documents Needed	Description	Submit	Program
	Tribal ID	Karuk Tribal ID/Certificate	Copy	LIHEAP, GA, CSD, LIAP
	State Drivers License or State Id	California drivers License or California State Id	Copy	LIHEAP, GA, CSD, LIAP
	Birth Certificate	Birth Certificate	Copy	LIHEAP, GA, CSD, LIAP
	Social Security Card	Social Security Card - **(Everyone in the household)**	Copy	LIHEAP, GA, CSD, LIAP
	Earned/Unearned Income	Applicant	Copy	LIHEAP, GA, CSD, LIAP
	Miscellaneous Income, or	Individuals 18 or older living in household	Copy	LIHEAP, GA, CSD, LIAP
	"No Income" Form	Individuals 18 or older living in household	Signed	LIHEAP, GA, CSD, LIAP
	Proof of Residence	Copy of electricity bill, propane, rental agreement etc.	Copy	LIHEAP, GA, CSD, LIAP
	Letter of Denial	A letter from an emergency resources agency stating services are denied or no services available. (Unemployment, SSA, SSI, Disability, Food Stamps, Food Commodities, Tribal Work Program, Non-Profit Agencies, Salvation Army, NCIDC, Tribal TANF, County TANF.	Copy	GA, CSD, LIAP
	Energy Bill	Electric, Gas, Propane, Kerosene, Natural Gas, etc.,	Copy	

(Tribal Members only)

LIHEAP (Low Income Heating & Energy Assistance Program)

HOME INFORMATION

Are you:

- ☐ Own/Buying
- ☐ Renting
- ☐ Caretaker
- ☐ Homeless
- ☐ Staying with

Type of dwelling:

- ☐ House
- ☐ Modular Home
- ☐ Mobile Home
- ☐ Travel Trailer
- ☐ Tent
- ☐

Is your utility bill included in your rent? ☐ No ☐ Yes

Are you on a community water system? ☐ No ☐ Yes

Well? ☐ No ☐ Yes

Utility service is in the name of: _____

Energy Assistance Requested:

Fuel	Heating/Cooling:	Other:
☐ Electricity	☐ Wood Stove	☐ Crisis
☐ Wood/Wood Pellets	☐ Monitor Heater	
☐ Propane/Kerosene	☐ Air Conditioner	
	☐ Swamp Cooler	

Weatherization needed: _____

(e.g., insulation for water heater, storm windows, etc.,)

PROGRAM SERVICES REQUESTED (Food, Shelter, Clothing, Special Needs, Crisis)

☐ **GA (GENERAL ASSISTANCE)**
(Federal Acknowledged Tribal Members Only)

☐ **CSD**
(Tribal Members) or (Lineal Descendants)

☐ **LIAP COMMITTEE**
(Tribal Members Only)

REASON FOR THE REQUEST (Only for GA, CSD and LIAP Committee)

A Detailed Explanation of what you are requesting

_____

_____

_____

_____

_____

_____

_____

_____

_____

LIAP APPLICATION CERTIFICATION

Initial (Each statement)

_____ I understand that I am responsible for the completion my application.

_____ If I submit an incomplete application, I understand that my application will be place on hold until all required documentation has been received by the LIAP program.

_____ I certify that all the information provided for this application is true and correct to the best of my knowledge and is subject to verification by the LIAP program.

_____ I have read and understand that falsification, misuse of program funds and any statement or documentation given on this application and in my file will be considered an intentional program violation and grounds for termination from this program for one (1) fiscal year from the date of determination. In addition, I understand that I may be subject to prosecution under the law.

_____ I understand that all information/documentation submitted for this application is confidential and no information/documentation obtained through this application shall be made public.

_____ Date_____

Signature of Applicant

_____ Date_____

LIAP Application's Preparer Signature (not the applicant) (this signature is used when applying for burial assistance)

LIAP APPEAL PROCEDURES

The applicant may appeal any adverse decision made by the Low Income Assistance Program (LIAP). The LIAP grievance process shall be as follows:

Step 1

The applicant shall submit an appeal, in writing, to the TANF Executive Director within 10 business days of receiving the LIAP adverse action. The TANF Executive Director shall review the LIAP Administrators decision, the applicant's appeal, the application and supporting documentation received by the LIAP and render a decision within 10 business days. If the applicant is not satisfied with the TANF Executive Director's decision, the applicant can appeal the decision to the LIAP committee.

Step 2.

The applicant shall submit in writing an appeal to the adverse decision to the LIAP Committee within 10 business days of receiving the TANF Executive Directors decision. The LIAP Committee shall review the LIAP coordinator decision, the applicant's appeal, the application and supporting documentation received by the LIAP coordinator, the TANF Director's Decision, and render a decision within 10 business days. If the applicant is not satisfied with the LIAP Committees decision, the applicant can appeal the decision to the Karuk Tribal Council .

Step 3.

The applicant shall submit in writing an appeal to the adverse decision to the Karuk Tribal Council within 10 business days of receiving the LIAP Committees decision. The Karuk Tribal Council shall review LIAP Administrator decision, the applicant's appeal, the application and supporting documentation received by the LIAP, the TANF Director's decision, and render a decision within 10 business days. The Karuk Tribal Council's decision is final.

APPENDIX A
RELEASE OF INFORMATION (ROI)

Consent for Release of Information

I, _____ (Legal Name), hereby authorize LIAP to release and/or exchange all information pertaining to my application and supporting documentation submitted to determine my eligibility in the Low Income Assistance Program.

This release of information is for the sole purpose of verifying the information providing on the application and verifying the supporting documentation.

I understand and consent to a photocopy of this authorization may be used for the purpose(s) stated above.

_____ Date: _____

Signature

Appendix B
LIAP APPEAL PROCEDURES

The applicant may appeal any adverse decision made by the Low Income Assistance Program (LIAP).

The following process are to provide the applicant with instructions on the procedure of filing an appeal.

1. Appeal in Writing

   All appeals must be in writing and be submitted to the TANF Executive Director, by the LIAP Administrator, who issued an adverse decision for services. The appeal must be signed and dated by the applicant.

2. Appeal Content

   The appeal must include at least the following information: the decision being appealed, and the reason for the client's disagreement with the action. **Client will provide a copy of the adverse decision Client must include a current mailing** address.

The LIAP grievance process shall be as follows:

Step 1

The applicant shall submit an appeal, in writing, to the TANF Executive Director with in 10 **business days of receiving the** LIAP adverse action. The TANF Executive Director shall review the LIAP Coordinator's decision, the applicant's **appeal, the** application and supporting documentation received by the LIAP and render a decision within 10 business days. **If the** applicant is not satisfied with the TANF Executive Director's **decision, the applicant can appeal the decision to the LIAP** committee.

Step 2.

The applicant shall submit in writing an appeal to the adverse decision to the LIAP Committee with in 10 **business days of** receiving the TANF Executive Director's decision. The LIAP Committee shall review LIAP coordinator decision, the applicant's appeal, the application and supporting documentation received by the LIAP, the TANF Director's **Decision, and render a** decision within 10 business days. If the applicant is not satisfied with the LIAP Committee's **decision, the applicant can** appeal the decision to the Karuk Tribal Council .

Step 3.

The applicant shall submit in writing an appeal to the adverse decision to the Karuk Tribal Council with in 10 **business days** of receiving the LIAP Committee's decision. The Karuk Tribal Council shall review LIAP coordinator decision, the applicant's appeal, the application and supporting documentation received by the LIAP, the TANF Director's **Decision, and render a** decision within 10 business days. The Karuk Tribal Council's decision is final.

APPENDIX C
LIAP STATEMENT OF MISCELLANEOUS EARNINGS

The Statement of Miscellaneous Earning is to be filled out by all adults, 18 years or older, listed on the individuals application, who is applying for LIAP assistance.

List all sources of earned/unearned income that have provided income for living expenses from October through Sepember

Month	Amount Received	Source of earned/unearned income
October		
November		
December		
January		
February		
March		
April		
May		
June		
July		
August		
September		

List how you are able to pay or the resources that provide for the following:

Housing: _____ _____
Name of source Street Address

Food: _____

Utilities: _____

Medical: ☐ County Medi-Cal/Medicaid/Medicare ☐ Healthy Families
☐ Karuk Tribal Health ☐ None

CERTIFICATION

Initials (For each statement)

_____ I certify the all the information provided above is true and correct to the best of my knowledge and is subject to verification.

_____ I understand the falsification of this information shall be grounds for termination from the LIAP Program for one fiscal year and may be subject to prosecution under the law.

_____ I further give my permission for the Karuk LIAP to verify all information provide on this form.

_____ _____ Date:_____
Print Name Signature

APPENDIX D
LIAP HARDSHIP REQUEST (BURIAL)

When filling out this Hardship Request there must be a LIAP application on fill for the Decedent. If one is not on file with Low Income Assistance Program (LIAP), then you must fill out a LIAP application on behalf of the deceased. This form will be submitted with the LIAP application.

REQUESTER

Relative to Decedent _____ Relationship to Decedent _____

Address _____

City, State, Zipcode _____ Telephone # _____

Other Resources: ☐ None ☐ Private Burial Insurance ☐ Checking/Saving Account ☐ Mortgages
☐ VA Plot ☐ Promissory Notes ☐ Retirement/Annuties

DECEDENT INFORMATION

Name of Decedent _____ Tribal Enrollment # _____

Date of Death: _____/_____/_____

FILING A HARDSHIP REQUEST (MUST BE SUBMITTED WITHIN 30 DAYS OF DEATH)

A LIAP application must filled out by the relative requesting assistance.

The relative filing for assistance must fill out the LIAP application. If LIAP has an application on file, the application must have been filed within the last six months. If the application is older than six months, then the application must be re-certified.

Required Documentation: Copy of Death Certificate
Copy of Funeral Invoice

Other Burial Assistance NEEDS:

CERTIFICATION
Initial (Each statement)

_____ By signing this hardship request, I do certify that the above information provided is true to the best of my knowledge and is subject to verification by the Low income assistance program. I have read and understand that falsification, misuse of program funds, and any statement made or documentation given both on this hardship request and in my file will be considered fraud and grounds for termination from this program for one (1) year from the date of determination and that I may be subject to prosecution under law.

_____ I understand that all information/documentation is confidential and will be used only to provide data from funding agencies, and no information/documentation obtained through this release shall be made public. Requester certifies that no other resources are available to the decedent to assistance with burial costs and all income sources of the decedent have ceased.

_____ _____
Signature Date

APPENDIX E
NON-MEDICAL ADULT CARE ASSISTANCE REQUEST

I _____, am requesting non-medical adult care assistance.

Days that I needed for adult care assistance: (Circle the days of assistance needed)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Need(s) Request:
(Circle Assistance needed)

Food Prep	Yard Work	Using the Phone
House Work	Transportatio	Walking
Shopping	Dressing	Other _____

(Circle one)

Are you currently receiving adult care assistance from the county? No Yes
If yes, then please provide a copy of county assistance document.

Do you currently have a Adult Care Assistance person providing services? No Yes
If yes, please provide the name of your current provider.

Name of Provider: _____

If you have a person that you would like to consider to provide the adult care assistance, please provide name.

Name of Person:_____

Telephone # _____

If you are being assisted with services from Karuk CHS, please provide the name of your CHS provider.

Name of CHS Representative _____

CERTIFICATION

Initial **(Each statement)**

_____ I certify that all the information provided for this application is true and correct to the best of my knowledge and is subject to verification by the LIAP program.

_____ I have read and understand that any false statement or documentation given on or with this application I will not be considered for employment.

_____ By signing below, you are giving the Karuk Tribal TANF Program the right to obtain a background check regarding your personal information.

_____ I understand that all information/documentation submitted for this application is confidential and no information/documentation obtained through this application shall be made public.

_____ Date_____