COMMUNITY NEEDS ASSISTANCE PROGRAM (CNAP) APPLICATION FY2019

CAP Office, 16429 Beartown Road, Baraga, MI 49908, Phone:(906) 353-4162, Fax: (906) 353-4179

***REQUIRED: ATTACH A COPY OF YOUR TRIBAL ID AS PROOF OF RESIDENCY, WITH YOUR CURRENT ADDRESS.**

HEAD OF HOUSEHOLD	PHONE #	REQUEST DATE
ADDRESS	COUNTY	TRIBAL ID#

NON-MEDICAL EMERGENCY ASSISTANCE (*Funding up to $275 per fiscal year for each household*).

$_____ Amount Requested – Please check which type of request below:

[_____] Home Repairs/Replacement of Appliances/Equipment (attach estimate or receipt).

[_____] Utility/Heating Disconnection Assistance (attach utility shut off/disconnect bill and amount due).

[_____] Vehicle Repair or Tire Replacement (attach estimate/receipt, current registration and insurance).

ADDITIONAL ASSISTANCE (*Additional funds are available with Tribal President Approval*).

[_____] Fire or Flood Assistance – For fire or flood damage involving a primary residence up to $1000.00.

[_____] Local Funeral Allowance – Request for up to 3 rooms for 3 days for out of the area immediate family.

[_____] Out of the Area Funeral Travel Allowance – up to $300 for immediate family member funeral travel.

MEDICAL TRAVEL/SERVICE ASSISTANCE *(Request up to $600 per fiscal year. Additional funds available for eligible applicants with chronic illness/conditions.)*

Do you receive medical travel assistance from Medicaid (UPHP), Veterans Affairs, Medical Transport Services, Healthy Start, Insurance, Workman's Comp. or any other agency: [_____] NO [_____] YES, if yes, you must provide a denial along with this request.

Please check which type of Medical Travel Assistance being requested below:

[_____] Medical travel specialists **[_____]** Overnight hospitalizations

[_____] Medical/surgical procedures **[_____]** Out the area travel to visit hospitalized immediate family

[_____] Medical alert services **[_____]** Sobriety/family therapy sessions to obtain

***REQUIRED: ATTACH VERIFICATION OF APPOINTMENT(S)/PROCEDURE(S) WITH PATIENT'S NAME, DATE AND TIME OF APPOINTMENTS, THE LOCATION AND LENGTH OF STAY.**

Specify in detail your type of request: ***(Include travel dates, times; location; lodging; food assistance; and if a driver is needed, etc.).***

___I hereby request assistance and I hereby authorize the release of information for myself or any other member in my household, in order to obtain information (including medical), specific to the KBIC CNAP application and related request.

___I agree for medical, to turn in verification of attendance, hotel receipts, and/or travel fund overages, within five (5) business days. I understand I will not receive future CNAP funding until the total amount of medical travel overages are paid in full.

Applicant Signature *Date*

Office Use Only

[_____] Approved – Recipient_____ $_____Amount

[_____] Denied – Reason _____

*CAP Administrator*_____ *Date*_____

You have a right to file an appeal for denials. Hearing process sheets can be obtained in the CAP office.

C.A.P. HOUSEHOLD APPLICATION FY2019

16429 Beartown Road, Baraga, MI 49908, Phone: (906) 353-6623 x4162, Fax: (906) 353-4141

Head of Household _____

Social Security # _____ **Age** _____ **Date of Birth** _____**Tribal ID#** _____

Physical Address _____

Enrollment Card required to apply for assistance (address must be current and updated with KBIC Enrollment Office).

Mailing Address_____

City _____ **State**_____ **Zip** _____**County** _____

Are you currently homeless? ☐ **YES** ☐ **NO** **Phone/Cell** _____

List of Household Members ***(Place a star * next to members who are attending college or in the service, etc.)***

LAST NAME	*FIRST NAME*	*RELATION TO HEAD OF HOUSEHOLD*	*DATE OF BIRTH*	*AGE*	*TRIBAL ID#*	*

Household Applicant Declaration

I agree to report changes in my household composition as they occur and I agree to report an address change and update with enrollment as required, to be eligible for CAP assistance.

I hereby authorize the release of information for myself or any other member in my household, in order to obtain information (including medical), specific to the Community Assistance Program application and related request.

I hereby certify that the above information of the household composition is correct and completed to the best of my knowledge and may be used for the purpose of verification when determining eligibility.

Head of Household _____ **Date** _____