COMMUNITY NEEDS ASSISTANCE PROGRAM (CNAP) APPLICATION FY2025

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

SERVICE AREA: BARAGA COUNTY & MARQUETTE TRUST PROPERTY ONLY (EXCEPT FIRE/FLOOD ASSISTANCE)

APPLICANT NAME	**PHONE #**	**REQUEST DATE**
PHYSICAL ADDRESS	**COUNTY**	**ENROLLMENT#**

NON-MEDICAL EMERGENCY ASSISTANCE (*up to **$500** per household each fiscal year*)

$_____ Amount Requested

□ Home Repair/Appliance Replacement (attach estimate or receipt)

□ Utility Disconnect (attach utility bill/disconnect notice)

□ Vehicle Repair/Tire Replacement (attach estimate/receipt, current registration and insurance)

□ Travel for Significant Life Event (College, University, Military, or Police Academy Graduation – attach proof)

ADDITIONAL ASSISTANCE (Requires President's Approval)

□ Fire/Flood Assistance – primary residence only – damages must exceed $1,000 (attach proof)

(PRIMARY RESIDENCE MUST BE LOCATED IN BARAGA OR MQT COUNTY FOR FIRE/FLOOD ASSISTANCE)

□ Out of the Area Funeral Travel: up to **$200** for immediate family member's funeral service (attach proof)

MEDICAL TRAVEL ASSISTANCE

MUST ATTACH DETAILED VERIFICATION OF APPOINTMENT, PROCEDURE, HOSPITALIZATION, ETC.

□ Medical Specialist Appointment
□ Medical/Surgical Procedure
□ Overnight Hospitalizations
□ Hospitalized Immediate Family Member
□ Family Therapy Session
□ Sobriety Travel

Specify in detail your type of request: ***(Include travel dates/times; location; lodging; food assistance; 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 this application and related request.

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

I acknowledge that this application is for funds to be used by the applicant only or, in the case of funds for medical or funeral costs, for a non-enrolled child under 18 years of age residing with the applicant. These funds may not be used for any other purpose and may not be used for the benefit of any other person.

I hereby affirm that I am not receiving funding from another agency or program for the same purpose.

I acknowledge that I have read both this document and the CNAP Guidelines and understand all of their contents. All of the information I have provided is true to the best of my knowledge and I understand that intentionally giving false or misleading information on this form could subject me to criminal charges or penalties and/or disqualification from receiving future CAP funds.

Signature_____ Date_____

SHADED AREA FOR OFFICE USE ONLY

[_____] Approved – Recipient_____ $_____Amount

[_____] Denied – Reason _____

*CAP Administrator*_____ *Date*_____

If you do not agree with this decision, you have a right to file an appeal.
Hearing process sheets can be obtained in the CAP office.