COMMUNITY NEEDS ASSISTANCE PROGRAM (CNAP)

ASSISTANCE REQUEST FORM

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

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

FOR OFFICE USE ONLY

Date Received: _____

CAP Staff Initials: _____

☐ Application Complete
☐ Household Application on File

APPLICANT NAME: _____ **KBIC #:** _____ **PHONE #:** _____

ADDRESS: _____ **COUNTY:** **Baraga** **Marquette**

Street Address City State Zip

TYPE OF ASSISTANCE REQUESTED (Check all that apply)

NON-MEDICAL ASSISTANCE

- Home Repair/Appliance Replacement (*Estimate/Receipt Required*)
- Vehicle Repair/Tire Replacement (*Estimate, Registration & Insurance Required*)
- Utility Disconnect (*Disconnect Notice Required*)
- Travel for Significant Life Event (*Graduation Verification Required*)

MEDICAL TRAVEL ASSISTANCE

- Medical Appointment
- Medical/Surgical Procedure
- Overnight Hospitalization
- Visit Hospitalized Immediate Family
- Visit Immediate Family in Nursing Home
- Family Therapy Session
- Sobriety Travel

ADDITIONAL ASSISTANCE

- Fire/Flood Assistance (*Requires President's Approval*)
- Funeral Assistance (Out of Area) (*Funeral Verification Required*)
- Serious Illness Assistance (*Requires President's Approval*)

DESCRIPTION OF REQUEST

Please describe your request. Include the reason for assistance, who the request is for (if not yourself), the type of repair or service needed, and any other information you would like us to consider.

IF REQUESTING MEDICAL TRAVEL ASSISTANCE – *Please complete this section & attach verification.*

PATIENT NAME: _____ **APPOINTMENT LOCATION** (City, State): _____

APPOINTMENT DATE: _____ **TRAVEL DATES:** _____ to _____

ASSISTANCE REQUESTED (Check all that apply): Mileage Meals Lodging Driver

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.

X_____ _____

Applicant Signature Date