



COMANCHE NATION OF OKLAHOMA SOCIAL SERVICES DEPARTMENT

Emergency Assistance Program Application

*******HOW TO SEND THE APPLICATION TO SOCIAL SERVICES*******

PO Box 908, Lawton, Oklahoma 73502

Office Phone: 580.492.3358/580.919.3167 Fax - 580.492.3742 Wk Cell 580.919.1121

Email - socialservices@comanchenation.com

Eligibility:

To be eligible for the Emergency Assistance Program, you must be an enrolled member of the Comanche Nation, 18 years of age and must be the Head of Household. The following documents are needed to complete your application:

- ✦ **Applicant's CDIB.** Comanche Enrollment Number #: _____
- ✦ **Utility assistance:** Copy of the utility bills with identifying account number. The copies of the utility bills will need to be at least within the last 30 days. If the utility bill is not in the applicant's name, we will require proof of residence (piece of mail, Driver License, etc).
*****Eligibility for utility assistance is 6 months from the last date you were approved if you have not exceeded your limit within the fiscal year*****
- ✦ **For new utility service:** Documentation must be provided identifying the company's name and information, applicant's name, new address, new account number, and balance due for each utility service.
- ✦ **Rental Assistance:** Must provide copy of the most current lease and a W-9 (if available to retrieve). Must provide proof of residence if applicant's name is not on lease. *****Eligibility for rental assistance is one time per fiscal year (Oct 2023 - Oct 2024)*****
- ✦ **Rental Deposit:** Must provide copy of the lease or a letterhead with the company's information, applicant's name, new address, and identifying deposit amount.
- ✦ **Mortgage Assistance:** Must provide copy of the most updated mortgage statement.
- ✦ **Property Taxes:** Must provide copy of the most updated property tax.
- ✦ **Medical Assistance:** Must provide a copy of the out of service area medical appointment (company's info, date & time) or a letter of admission for the immediate family member from an out of service area hospital. Will not reimburse for any expenses. All documentation needs to be submitted before the discharge date or prior to the scheduled medical appointment.
Same day discharge/appointments will not be accepted.

BY SIGNING BELOW:

- I understand I must submit all the required documents before my application will begin the review process.
- I understand that I have a period of two (2) weeks to submit all the necessary documentation or my case will be closed out.
- I understand that there is a six (6) month waiting period in between utility assistance, so as long as I am eligible and shelter assistance is ONCE per fiscal year (Oct 1st - Oct 1st).

Applicant Signature

Date

Emergency Assistance Program Application

APPLICANT INFORMATION:

Name: _____ Maiden: _____
DOB: _____ SSN: _____ CDIB Enroll #: _____
Physical Address: _____ City, State, Zip: _____
Mailing Address: _____ County: _____
Home/Cell Phone: _____ Work Phone: _____
Email Address: _____

HOUSEHOLD MEMBERS (Do not include self):

<u>First and Last Name</u>	<u>DOB</u>	<u>Tribe</u>	<u>Relationship</u>

TYPE OF ASSISTANCE REQUESTING:

Documents verifying the amount needed for assistance must be submitted with application

Shelter(R/M/P) _____ Electric: _____ Water: _____ Gas: _____ Propane: _____
Other: _____ Name of Propane Company: _____

PLEASE STATE THE REASON FOR ASSISTANCE:

CLIENT(S) STATEMENT OF RIGHTS AND RESPONSIBILITIES:

I understand that if I willingly and fraudulently provide false information for the purpose of obtaining benefits I may be ineligible for assistance. *****Reminder to sign the first page*****

Applicant Signature _____ **Date** _____

Social Service Representative _____ Date _____

For office use only:

EM Asst approved amount: _____	Utility Company: _____	RQ #: _____
EM Asst approved amount: _____	Utility Company: _____	RQ #: _____
EM Asst approved amount: _____	Utility Company: _____	RQ #: _____
EM Asst approved amount: _____	Shelter Name: _____	RQ #: _____