



EMERGENCY & EMERGENCY TRAVEL ASSISTANCE APPLICATION FORM

Name: _____
First Middle Last (Maiden)
Address: _____
City: _____ State: _____ Zip Code: _____
Delaware Tribal Registration Number: _____ Applicant Phone: _____
Date of Birth: _____ Age: _____ E-Mail: _____

Programs:

- **(EMERGENCY)**: Provides emergency assistance to Delaware Tribal members. Funds are to be used for Emergency situations. Documentation must be provided. Applicants must utilize all other community resources prior to application. Funds are allocated up to \$400 and will be disbursed as determined by the Community Service Committee on a case-by-case basis. **Receipt or proof of expenditure must be provided.**
- **(EMERGENCY TRAVEL)**: Provides assistance for Delaware Tribal members to include, but not limited to, health/medical transportation costs, assistance and/or other related costs. Emergency travel designated as personal health, physician's statement of need must be submitted, death of a family member (parent, brother, sister or grandparent), death certificate or obituary must be submitted prior to approval. This is a once per calendar year assistance not to exceed \$200.

Required Documentation:

- ✓ Copy of service provided billing/estimate or receipt. Provider name, address, phone, contact person and date of service **MUST** accompany the application.
- ✓ Copy of a photo ID (Driver's license, tribal photo ID) and Tribal enrollment card **MUST** accompany the application. Contact Enrollment Office for Cards.
- ✓ A short statement about situation for which assistance is needed.
Incomplete applications are not considered.
 - Approval of application must be obtained prior to the service payment.
 - Non-Tribal members are not eligible for services.

Vendor/Tribal Member Name *(To whom check should be issued)*: _____

Address: _____

City: _____ State: _____ Zip: _____

**Applications are approved on a case by case basis. Emergency applications are considered as received. Any tribal member purposely attempting to defraud the committee will be ineligible for any community service program for a period of one (1) year. (Applications are subject to change)*

Community Service Committee Use Only:

Approved By: _____ Date: _____

Total Amount: \$ _____

Denied By: _____ Date: _____ Reason for Denial: _____

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**** As of April 30, 2021, You will no longer need to provide Income Verification, such as a paycheck stub, for Community Service. This does NOT apply to LIHEAP! ****

1. How many members are in the household _____
2. Total gross household income _____
3. List all sources of income _____

By signing this form, I acknowledge that the information I have provided is true and/or correct to the best of my knowledge.

Signature of Applicant

Date

Personal statement: