

# YUROK SOCIAL SERVICES



## EMERGENCY ASSISTANCE APPLICATION

**Main Office**  
PO Box 1027  
Klamath, CA 95548  
Phone (707) 482-1350  
Fax (707) 482-1368  
Toll Free 1-800-242-0684

**Humboldt Office**  
525 7<sup>th</sup> Street  
Eureka, CA 95501  
Phone (707) 445-2422  
Fax (707) 445-2428

### CHECKLIST

The following information must be provided before your request can be submitted:

- Completed Application
- Income Verification for all Household Members
- All Household Names and Information (Including Social Security #'s)
- Tribal Verification
- Verification of Need \* (see below)
- Written documentation in the event of an emergency situation \*

\* All services requested require appropriate documentation from vendors ex: Eviction Notice, 48 hour shut-off notice, etc. Emergency medical travel requests must be accompanied by a doctor's appointment or referral verification.

Payments will be made directly to the vendor except in cases of medical emergency travel. Arrangements must be made in advance whenever possible. Receipts must be submitted to Social Services as soon as possible.

# Emergency Assistance Application

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
**Physical** Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Message Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ S.S.# \_\_\_\_\_ Tribal ID #: \_\_\_\_\_  
 District: South \_\_\_ East \_\_\_ North \_\_\_ Orick \_\_\_ Requa \_\_\_ Pecwan \_\_\_ Weitchpec \_\_\_

**List all Household Members (relationship to applicant) and ages:**

| <i>Name</i> | <i>DOB</i> | <i>Age</i> | <i>Tribal Roll #</i> | <i>SS#</i> |
|-------------|------------|------------|----------------------|------------|
|             |            |            |                      |            |
|             |            |            |                      |            |
|             |            |            |                      |            |
|             |            |            |                      |            |
|             |            |            |                      |            |
|             |            |            |                      |            |
|             |            |            |                      |            |

*Monthly Income of all Household Members:*

| <b>SOURCE</b>       | <b>NAME</b> | <b>AMOUNT</b> |
|---------------------|-------------|---------------|
| WAGES               |             |               |
| TANF/CALWORKS       |             |               |
| SOCIAL SECURITY/SSI |             |               |
| UNEMPLOYMENT        |             |               |
| VETERANS BENEFITS   |             |               |
| OTHER               |             |               |
| <b>TOTAL</b>        |             |               |

Describe your emergency situation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Certification:** By signing this document I am certifying that all information provided, oral and written are true. I acknowledge that such information is subject to verification and that falsification of this information shall be grounds for denial and/or reimbursement of funds received from this program. I am the only person in my household who had applied for this program.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## AUTHORIZATION TO RELEASE INFORMATION

PO Box 1027  
Klamath, CA 95548  
Phone (707) 482-1350  
Fax (707) 482-1368

3969 Walnut Dr.  
Eureka, CA 95503  
Phone (707) 444-6295  
Fax (707) 444-6297

I, \_\_\_\_\_, hereby authorize Yurok Social Services, a department of the Yurok Tribe, and the organizations and/or individuals indicated below by my initials to release and receive information concerning my case and/or the case of my dependent(s) named below. I have been informed of the type of information to be requested and released.

Initial all that apply:

\_\_\_\_\_ Department of Health and/or Social Services of \_\_\_\_\_ County.

\_\_\_\_\_ Probation Department of \_\_\_\_\_ County.

\_\_\_\_\_ United Indian Health Service and/or the following clinics and health programs:

\_\_\_\_\_

\_\_\_\_\_ Juvenile and/or Dependency Court of \_\_\_\_\_ County

\_\_\_\_\_ The following school(s) \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ My dependents who are covered by this release are: \_\_\_\_\_

\_\_\_\_\_

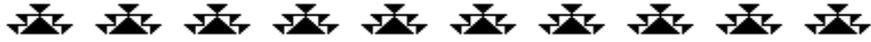
\_\_\_\_\_ I hereby release the Yurok Tribe and its agents and employees from any/ all liabilities, responsibilities, damages and claims which might result from release of information authorized above.

\_\_\_\_\_ I understand that the above consents are subject to revocation by me at any time, except to the extent that action has been taken in reliance on this consent prior to revocation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This release will be in effect for one year from the date it is signed unless terminated earlier at the request of the client



## WHAT ASSISTANCE ARE YOU APPLYING FOR

**Please check one:**

**Emergency Medical Transportation (bus tickets, gas):\_\_\_\_\_**

**Rent/Mortgage (past due):\_\_\_\_\_**

**New Housing (Deposit):\_\_\_\_\_**

**Emergency Food/Clothing/Hygiene:\_\_\_\_\_**

**(Receipts MUST be submitted to Social Services within 5 business days of using vouchers)**

**Utilities (Past Due)\_\_\_\_\_**

**\*\* Be sure to complete all of the necessary information in order for your application to be processed. Your application will remain active for ten (10) days in order to give you the opportunity to collect the documentation needed. After ten (10) days, the application will be inactive and you will need to re-apply again if assistance is still needed.**

# YUROK SOCIAL SERVICES



## RESPONSIBILITY STATEMENT

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I, \_\_\_\_\_, reside at  
Print Name

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**Physical Address**

City

State

Zip

My utility bill is in the name of \_\_\_\_\_. I am responsible for payment of the utility bill for the above address. He/She is my \_\_\_\_\_.

If bill is not in your name, you are responsible for payment of the utility bill for the above address because \_\_\_\_\_

\*I certify that all information is true and correct to the best of my knowledge.

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**Applicant Signature**

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**Date**