YUROK SOCIAL SERVICES

Application For Assistance

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 7th Street
Eureka, CA 95501
Phone (707) 445-2422
Fax (707) 445-2428

CHECKLIST

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

Completed Application

- ❑ **Tribal Verification**
- ❑ **All Household Names and Information (Including Social Security #'s)**
- ❑ **Income Verification for all Household Members**
- ❑ **Verification of Need*(Copy of power bill if requesting LIHEAP)**
- ❑ **Proof of Handicap or Disability (If requesting LIHEAP)**

Written documentation in the event of an emergency situation

*All services requested require appropriate documentation from vendors. Emergency medical travel requests must be accompanied by a doctor's appointment or referral verification.

Payments will be made directly to 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.

Adopted: 9/06
Revised: 10/10

Application For Assistance

Client Name:_____ Tribal ID #: _____ DOB:_____

Mailing Address:_____ City:_____ Zip:_____

Telephone:_____ S.S.#_____

District: South___ East___ North___ Orick___ Requa___ Pecwan___ Weitchpec___

LIST ALL HOUSEHOLD MEMBERS (other than self)

NAME	DOB	Age	Tribal Roll #	SS#

MONTHLY INCOME FOR ALL HOUSEHOLD MEMBERS

SOURCE	NAME	AMOUNT
Wages		
TANF/CalWorks		
Social Security/SSI		
Unemployment Benefits		
Veteran's Benefits		
Other		
TOTAL		

Describe your 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:_____

Adopted: 9/06
Revised: 10/10

YUROK SOCIAL SERVICES

AUTHORIZATION TO RELEASE INFORMATION

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

525 7th Street
Eureka, CA 95501
Phone (707) 445-2422
Fax (707) 445-2428

I, _____, hereby authorize Yurok Social Services, a department of the Yurok
(print name)
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.

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

_____

_____ Probation Department of _____ County.

_____ My dependents who are covered by this release are: _____

_____

_____ Juvenile and/or Dependency Court of _____ County

_____ The following school(s) _____ _____

_____ Other _____

_____ 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 consent is 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.

_____ _____
SS# **DOB**

_____ _____
Applicant Signature **Date**

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

Adopted: 9/06
Revised: 10/10

YUROK SOCIAL SERVICES

Verification of Unemployment/No Income

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

Humboldt County Office
525 7th Street
Eureka, CA 95501
Phone (707) 445-2422
Fax (707) 445-2428

Fill out for each person in household 18 years or older without employment or any income

I_____am currently unemployed and/or not
(Print Name)
receiving any benefits or income.

Last employer: _____ Date last worked: _____

Reason no longer working: _____
_____
_____

I certify that all information is true and correct to the best of my knowledge. I am also aware that Yurok Tribe Social Services may verify my status with the Employment Development Department or other necessary agencies. I acknowledge that such information is subject to verification and that falsifying of this information shall be grounds for denial and reimbursement of any and all funds received from this program.

_____ _____
Signature **Date**

Adopted: 9/06
Revised: 10/10

YUROK SOCIAL SERVICES

TYPE OF ENERGY ASSISTANCE NEEDED:

☐ Electric ☐ Propane ☐ Kerosene/ Diesel Monitor Heater ☐ Pellets

☐ Wood Length of Wood ____ inches Preference: Hardwood or Fir (circle)

☐ Other:_____

Name of Vendor for Energy Assistance:_____

Account Number:_____

LIHEAP
FAIR HEARING STATEMENT

Client Rights- If you wish to appeal any decision regarding your application.

- If you feel the decision of the LIHEAP Intake Staff is in error, you may file a written appeal within ten (10) days after receiving a letter of denial to the Social Services Director.
- The Social Services Director will review and make a decision regarding your appeal within five (5) days after receiving your written appeal.
- If the Social Services Director upholds the initial decision, you have ten (10) days after receiving their written decision to file a written appeal to the Yurok Tribal Council. The Yurok Tribal Council then has ten (10) days to receive their final written decision by mail.

I have read the above rights and have been advised of my rights to appeal any decision made by the LIHEAP Intake Staff.

_____ _____

Signature of Applicant **Date**

Adopted: 9/06
Revised: 10/10

YUROK SOCIAL SERVICES

LIHEAP

RESPONSIBILITY STATEMENT

I, _____, reside at
Print Name

_____
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.

_____ _____
Applicant Signature **Date**

Adopted: 9/06
Revised: 10/10