

**TUNICA-BILOXI TRIBE OF LOUISIANA
CARES FUND**

APPLICATION FOR FINANCIAL ASSISTANCE

Eligibility of Funds is subject to (1) Completion of this Application, (2) Submission of all required documents and other information, (3) Compliance with the Program Guidelines, and (4) Review and approval by the Tunica-Biloxi Tribe's CARES Assistance Committee.

Date of Application: _____ Tribal Roll Number: _____

Full Name:

First Name

Middle Name

Last Name

Date of Birth: _____ Social Security #: _____

Address: _____

Telephone #: _____ Marital Status: _____

Other Contact Information (optional): _____

Is the Qualifying Event for Which Funds are Requested Related to Covid-19:

_____ Yes _____ No

** Event related to Covid-19 outside the control of applicant or member of household
(describe below)

Amount Requested \$ _____

Date on which Qualifying Event occurred: _____

Provide Details of the Covid-19 Qualifying Event:

List all assistance needed at this time due to Covid-19:

List all current sources of Household Income, including **ANY** disbursements from the Tribe:

Check or List other resources your have received or for which you have applied:

_____ Unemployment Insurance	_____ FEMA/Federal or State Disaster Relief
_____ Disability Insurance	_____ Medicare / Medicaid
_____ Workers' Compensation Insurance	_____ Social Security Disability
_____ Health Insurance	_____ Religious/Charitable Organizations
_____ Life Insurance	

NOTE: IN MOST CASES YOU WILL BE REQUIRED TO SUBMIT PROOF THAT YOU HAVE APPLIED FOR ASSISTANCE FROM ONE OR MORE OF THE ABOVE SOURCES.

List all Tribal Members living in your household:

Spouse (name): _____

Children (name): _____ Age: _____

Others Members of your household (name and relationship to applicant):

List all checking, savings and investment accounts that are held in your name or the name of your spouse and the value of each such account:

Checking and Savings Accounts:

Name(s) of Financial Institution(s) _____ Current Balance: _____

Investment/Securities Account(s):

Name of Financial Institution _____ Account Value: _____

THIS APPLICATION MUST BE ACCOMPANIED BY SUPPORTING DOCUMENTATION, INCLUDING BUT NOT LIMITED TO:

Death Certificate

Invoices for Medical Costs

Receipts showing payments made to service providers or vendors

Rental or Lease Agreement

I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for denial of assistance present & future.

Signature: _____ Date: _____

