

**TUNICA-BILOXI TRIBE OF LOUISIANA  
CATASTROPHIC RELIEF 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 Community Service Committee.

Date of Application: \_\_\_\_\_ Tribal Roll Number: \_\_\_\_\_

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Full Name:

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name

\_\_\_\_\_  
Last Name

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Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Other Contact Information (optional): \_\_\_\_\_

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Qualifying Event for Which Funds are Requested (check one):

\_\_\_\_\_ Loss of Primary Residence due to an act of God or accident.

\_\_\_\_\_ Personal Injury or Illness rendering individual unable to work for one month or more.

\_\_\_\_\_ Other Catastrophic Event outside the control of applicant or member of household (*describe*)

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Amount Requested \$ \_\_\_\_\_

Date on which Qualifying Event occurred: \_\_\_\_\_

Provide Details of the Qualifying Event:

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

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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	

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***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.***

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List all Tribal Members living in your household:

Spouse (name): \_\_\_\_\_

Children (name): \_\_\_\_\_ Age: \_\_\_\_\_

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Others (name and relationship to applicant):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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

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**IN THE EVENT YOUR APPLICATION IS APPROVED, PAYMENTS WILL BE MADE DIRECTLY TO SERVICE PROVIDERS AND VENDORS, NOT TO THE INDIVIDUAL APPLICANT (EXCEPT IN CASES WHERE APPLICANT IS SEEKING REIMBURSEMENT FOR PAYMENTS HE/SHE HAS ALREADY MADE AND PROVIDES PROOF)**

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*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: \_\_\_\_\_

APPROVED

DENIED

Date: \_\_\_\_\_




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## Monthly Expense Report

Name: \_\_\_\_\_

Date	Description—Mortgage/Rent/Utilities/Other Expenses	Amount Due	Total
Subtotal			
Less cash advanced			
Total owed to you			
Total due			

Any PAST DUE amounts: \_\_\_\_\_

Any receipts of payment should be submitted with this expense report