



**DEPARTMENT OF SOCIAL SERVICES
ECONOMIC ASSISTANCE PROGRAM**

CRITICAL CARE/DISASTER RELIEF ASSISTANCE

P.O. Box 40, Black River Falls, WI 54615
Phone (715) 284.2622 X 5104 (888) 343.8190 X 5104
FAX (715) 284.9486

Economic Assistance funds are limited to families experiencing financial hardships. **All assistance will be paid to the vendors assisting tribal members in their time of need.**

- ❖ **Critical Care**—Critical Care/Terminal Illness is defined as emergency hospitalization and/or admittance to an intensive care unit of a hospital. Assistance may be available for immediate family members only, (example: mother, father, sister, brother, daughter, son & spouse), and limited to expenses the hospital cannot cover. Extended family member approval is on a case-by-case basis depending on available funds. Assistance for travel are only available to those outside a fifty mile radius from their home address.
- ❖ **Disaster Relief**—Fire, Flood, Tornado or other weather related displacement.

ELIGIBILITY REQUIREMENTS

1. Must be an enrolled Ho-Chunk Nation tribal member.
2. Must have already taken a per capita loan.
3. Has exhausted all other resources **prior** to requesting assistance from EAP and provides a letter of decision.
4. All household income verification must be provided (check stubs last 3 months)
5. For Critical Care Assistance, verification of family member being in the ICU is required.

THIS IS NOT AN ENTITLEMENT PROGRAM. The Economic Assistance Program is a payer of last resort. Economic Assistance requests are available to enrolled Ho-Chunk members only and reviewed on a case by case basis. In order to be considered for funding, the applicant **must** meet the criteria and provide all required documents established by the program to ensure fairness and equity. The fiscal year begins July 1 and ends June 30. **The maximum amount of assistance is \$600.00.**

ALL PROGRAM DECISIONS ARE FINAL. If the applicant disagrees with the decision, they may request a review of the decision by submitting an appeal in writing to the Ho-Chunk Nation Executive Director of Social Services. **All program decisions are final and may not be appealed to the Office of the President or Ho-Chunk Nation Legislature.**

Please check which type of assistance you are requesting

<i>Critical Care</i>	<i>Disaster Relief Lodging</i>	<i>Disaster Relief Food</i>	<i>Disaster Relief-Housing (First Month's Rent)</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's Last Name	First	MI	Maiden	Date of Birth	Veteran	Elder	Soc. Sec. #	Enrollment #
					<input type="checkbox"/>	<input type="checkbox"/>		

Mailing Address	Physical Address

County	Area <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	# of Dependents in household	# of Adults in household
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Home Phone	Cell Phone	Message Phone	Email

Name of Employer	Length of Employment Mo: Yr:	Part Time <input type="checkbox"/>	Full Time <input type="checkbox"/>
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List ALL members of household Last Name First MI Maiden	Date of Birth	Social Security #	Enrollment #

Gross Income for each member of household	Applicant Weekly/Monthly	Spouse/Partner Weekly/Monthly	Additional Person Weekly/Monthly	Additional Person Weekly/Monthly
Wages				
Social Security/SSI Disability				
Unemployment/VA Benefits				
Workman's Comp/W2				
Per Capita				
Child Support				
Other:				
Total Monthly Household Income:				

HCN DSS
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize the Ho-Chunk Nation Department of Social Services, (Economic Assistance Program-CSS), to disclose to Ho-Chunk Nation Department of Treasury (per capita loan verification), Ho-Chunk Nation Enrollment Department (per capita deductions), and :

(Name of person/organization to which disclosure is permitted, could include energy/utility company, landlord, hospital or county social services)

personal information and documents that will assist in processing my request for assistance, including financial data, present need for services, related history and records for case file, and social/case history through telephone or written consultation.

The purpose of this authorization is to enable the Economic Assistance Program to: establish need, determine eligibility, verify statements, and process my request for assistance from the Ho-Chunk Nation Department of Social Services and/or any other programs for which I may qualify. I understand that my records are protected under federal regulations governing Confidentiality of Records and cannot be disclosed without written consent unless otherwise provided for in the regulations.

This consent will expire one year from this date:

_____. (Today's Date)

Signature of Client(s)

Signature of Authorized Representative-(for Incapacitated Client)

(Date)

Subscribed and sworn to before me

This _____ day of _____, 20____

Signature _____

My Commission Expires: _____

Understanding Your Rights and Responsibilities

- I have read and understand the policies and procedures of the Economic Assistance Program's Critical Care/Disaster Relief.
- I authorize the Ho-Chunk Nation Economic Assistance Program to verify personal information and documentation
- I understand the Economic Assistance Program receives information from other state and federal agencies to verify the information I give them. If I misrepresent, hide or withhold facts which may affect my eligibility, it will automatically void this application, I will be required to repay any/all assistance received and will no longer be eligible for future assistance from the Economic Assistance Program. This may also subject me to prosecution for fraud.
- I understand that the information provided on this application will be kept confidential and will only be used to determine eligibility.
- I understand that I will receive written confirmation of the decision in writing within fifteen (15) working days.
- I understand that all information provided on this application are true and complete statements and facts.

ANY ABUSIVE WORDS OR THREATENING ACTIONS WILL NOT BE TOLERATED & MAY RESULT IN DENIAL OF SERVICES.

Applicant Signature

Date