APPLICATION FOR HOUSING/UTILITIES ASSISTANCE THROUGH THE CARES ACT FUNDING CHECKLIST

- ☐ Copies of Tribal IDs for everyone in the household
- ☐ Copy of Utilities bill (if requesting assistance with Utilities)
- ☐ Copy of Mortgage Statement (if requesting assistance with Mortgage)
- ☐ Copy of Rental Agreement (if requesting assistance with rent)
- ☐ Proof of how you have been impacted by COVID **(**furlough, reduced hours, loss of job, or increased expenses, please attach proof)
- ☐ All adults (18+) have signed the application
- ☐ Verification of income for all adults (18+)

Clear Form | Print Form

TULALIP TRIBES
HOUSING DEPARTMENT

Application for Housing/Utilities Assistance through the CARES Act Funding

OFFICE USE ONLY:
Application Received:
Name:_____
Date:_____
Received By:_____

PLEASE ATTACH A COPY OF YOUR TRIBAL ID

Applying For: ☐ Utilities Assistance ☐ Rent/Mortgage Assistance

NOTE: **You must attach a copy of your mortgage/rent invoice and/or utilities bill depending on the type of assistance you are requesting.** Information provided on this application is subject to verification. You will be determined eligible or ineligible based on the information you provide in this application.

APPLICANT INFORMATION:

First Name:_____ Last Name:_____ M.I.:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Message No.:_____

HOUSEHOLD COMPOSITION: List the Head of Household and ALL persons living in the home.

First Name	Last Name	Relationship	Birth Date	Tribal ID	
		Self			

INCOME INFORMATION: List below all sources of income for every family member. Include all income: such as wages, public assistance, TANF, all benefit payments, net income from a business, child support, fishing income, PER CAPITA payments, etc. Please attach proof (paycheck stubs or other verification)

Family Member	Source of Income	Amount	Payment Basis (Weekly, Monthly, Etc.)

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Application for Housing/Utilities Assistance
(*Continued*)

ADDITIONAL INFORMATION: Please state how the COVID Pandemic affected your household (Furlough, Reduced hours, loss of job, or increased expenses, please explain and attach proof)

Has anyone in your household received assistance from the CARES Act?
If yes, please explain:

APPLICATION CERTIFICATION: I/ We certify that all information provided in this application is true, complete and accurate to the best of my knowledge. I/We authorize the Tulalip Tribes Housing Department to verify all information provided on this application. I/We understand that supplying false information may result in denial and/or termination of assistance.

Date:_____ Head of Household Signature:_____

Date:_____ Other Adult Signature:_____

Please be aware that by emailing this form you are sending your information to an unencrypted email at your own risk. You can opt to fax your information to 360-716-0130.

HOUSING DEPARTMENT USE ONLY

☐ Indian Housing Plan Abbreviated ☐ Indian Community Block Grant

☐ Non-Program Funds

Eligibility Determination: ☐ Approved ☐ Ineligible
If ineligible, please state why: _____

Date:_____ Determination Made By:_____

Date:_____ Approved By:_____

Tulalip Housing COVID-19
Consent for Release of Information (ROI)

HOUSING DEPARTMENT

_____ _____/_____/_____

Client Name **Client Date of Birth**

I hereby authorize the exchange of confidential information specified below between:

INFORMATION TO BE RELEASED FROM:

◯ **Tulalip Housing Department**

INFORMATION TO BE RELEASED TO:

◯ Any Tulalip Tribal Department with COVID-19 services

I understand that my records are protected under the federal and state confidentiality regulations (42 CFR, Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA, 45 CFR, part 164.
I also understand that I may revoke this consent at any time, if done in writing, except to the extent that action has been taken in reliance of it. I further acknowledge that the information to be released has been fully explained to me and this consent is given of my own free will.

_____ _____ _____/_____/_____

Print Name Signature Today's Date

This authorization will expire 1 year from the date entered here_____. If no date is entered, release will automatically expire in 6 months of the date signed.

Notice of Redisclosure of Confidential Information
This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, part 2). The federal rules may prohibit you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for his purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.