



Membership Distribution Request for Income Verification

Adult Name: _____ Tribal ID #: _____

Adult Name: _____ Tribal ID #: _____

MONTHLY PER CAPITA HISTORY

Year Needed:

2013 2014 2015 2016 2017 Current Year

Months Needed:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

LETTER

Choose One: Per Capita Elder Support Programs Disability Senior

Other: _____

Children Included on Verification:

Name: _____ Tribal ID #: _____ Date of Birth: _____

Name: _____ Tribal ID #: _____ Date of Birth: _____

Name: _____ Tribal ID #: _____ Date of Birth: _____

Name: _____ Tribal ID #: _____ Date of Birth: _____

Name: _____ Tribal ID #: _____ Date of Birth: _____

Name: _____ Tribal ID #: _____ Date of Birth: _____

Choose One:

Pick Up: _____ Contact #: _____

Email To: _____

Fax To: _____

Mail To: _____

Signature: _____ Date: _____

NO POWER OF ATTORNEY WILL BE ACCEPTED.

Please allow 48 hours for income verification to be completed.

Questions?

Phone: 360-716-4364 | **Email:** membershipdistribution@tulaliptribes-nsn.gov | **Fax:** 360-716-0304