Physical location:
2640 West Point Rd.
Green Bay, WI 54304
Mailing: P.O. Box 365
Oneida, WI 54155

ONEIDA

Telephone:
920.490.3939
1.800.216.3216
fax: 920.490.6803
www.oneida-nsn.gov

Community Support Application

Community Support Program is designed for Oneida enrolled members during times of catastrophic illness, injury, or emergency event when no other resources for assistance exist. The Community Support Fund is funded by Tribal Contribution, services are subject to funding availability.

Description:

Catastrophic event means a natural or man-made incident, which results in substantial damage or loss requiring major financial resources to repair or recover (i.e. house fire, tornado, flood, or other disaster).

Catastrophic illness or injury means a serious debilitating illness, injury, impairment, physical or mental condition.

Emergency event means a situation that poses an immediate risk to health, life, safety, property or environment.

Eligibility Criteria:

Applicant must be an enrolled Oneida Nation member, or the application needs to be on behalf of another person who is a Oneida Tribal member otherwise unable to do so due to age or incapacity. Applications for assistance for minors must be made by parent or legal guardian. Supportive services may have additional criteria to meet eligibility.

If the application is incomplete or missing required verifications, you will receive notification. Applications are valid for 30 calendar days from date received. If you fail to provide the required verifications within the 30 days, you will receive notification that your application expired and must reapply. Please allow 14 business days for processing of applications.

ALL APPLICATIONS REQUIRE THE FOLLOWING VERIFICATIONS:

- Tribal enrollment verification (Tribal ID card or enrollment letter)
- Proof of all household income for the last 30 days (TANF/W2, pay stubs from employment, unemployment, SSI, SSDI, disability payments, workman's compensation, child support, alimony, veteran's benefits, self-employment (tax return), etc.)

SERVICES AVAILABLE AND REQUIRED VERIFICATION:

Auto Repair

- Valid Driver's License
- Valid Vehicle Registration
- Verification of critical medical appointment or ongoing care
- Two estimates from ASE certified auto repair services (unless vehicle is not safe to drive, noted on estimate)

Catastrophic Shelter Assistance

- Verification of catastrophic event, illness, or injury (unable to work, being incapacitated with start and expected to return dates)
- Landlord Verification Form (agency form)
- Current Rental lease agreement/Mortgage Statement
- Last 60 days of income to show interruption of income
- FMLA from employer
- Verification of Short/Long term disability

Cobra Insurance

- Verification of current group health insurance policy
- Verification of all state and public benefits applied for if eligible
- Written estimate of employer's group health care coverage plan premium for COBRA coverage

SERVICES AVAILABLE AND REQUIRED VERIFICATION (Continued):

Critical Medical Bill Assistance
- Medical statement showing dates of services and balances after insurance has paid
- Copy of explanation of benefits from your current insurance provider
- Verification of application for any community/financial assistance from facility

Emergency/Non-Emergency Medical Travel – Must be within 30 days
- Emergency Travel Reimbursement
  - Verification of Driver's License for fuel reimbursement, original receipts for hotel, gas, and/or airfare
  - Verification of medical condition, date, time and location
- Non-Emergency Travel
  - Verification of Driver's License for fuel reimbursement, original receipts for hotel, gas, and/or airfare
  - Verification of medical appointment must be more than 60 miles one way from place of residency

Dental Related Expenses
- Verification by a dentist, orthodontist, or oral surgeon of the dental procedures to be completed and that they are medical need, not cosmetic
- Cost estimate of services and/or dental bill, Dental insurance

Family Medical Leave Act Wage Replacement
- Verification that the caregiver has been employed with their company for at least 12 months, and must have worked for at least 1250 hours in the last 12 months
- Verification of approved FMLA or equivalent leave from the caregiver's employment
- Verification of the medical need requiring full-time care of the immediate family member

Fire/Natural Disaster Assistance
- Police and/or fire department report verifying disaster
- Verification of assistance provided or applied for from American Red Cross or FEMA
- Verification of all household members at the time of natural disaster

Funeral Travel Reimbursement – Must be within 30 days max of $500 reimbursement
- Obituary – verification of immediate family member (father, mother, sister, brother, grandmother, grandfather)
- Verification of Driver's License for fuel reimbursement, original receipts for hotel, gas, and/or airfare

Inpatient/Outpatient Treatment Services
- Cost estimate of the Treatment Center including name, address, and Federal Tax ID number
- Verification that applied for any community/financial assistance from facility
- Verification of referral from licenses or certified counseling agency or program verifying the catastrophic illness

Medical Related Equipment Supplies or Furniture
- Cost estimate of supplies, equipment, or furniture prior to purchasing
- Medical verification from licensed medical physician specifying if need is short-term basis, life threatening or chronic medical condition, and that is required to improve or maintain quality of life

Optical Related Assistance
- Cost estimate and or bill of Optical services including name, address, and Federal Tax ID number, optical insurance
- Medical verification from ophthalmologist, optician, or optometrist

Prescription Reimbursement Assistance
- Verification that emergency medical prescription was needed after hours (emergency room report or discharge summary)
- Original receipts of prescription medication

Security Deposit Assistance
- Landlord Verification Form completed by landlord, signed by applicant
- Rental Lease Agreement
- Verification of emergency situation (eviction, foreclosure, etc.)

Social Security Disability Determination Shelter/Utilities Assistance
- Verification of current Social Security Disability Application filed and status
- Utility bills (water, heat, electricity)

Utility Disconnect Assistance
- Disconnection notice and verification of applied for Energy Assistance
- Verification of payments made in each of the previous three (3) months

Community Support Fund Application
CHECK ALL SERVICES YOU ARE APPLYING FOR

ONEIDA

OFFICE USE ONLY
Received _____
Documents needed _____
_____
_____
Intake _____
Caseworker _____

- ☐ Auto Repair
- ☐ Cobra Insurance
- ☐ Medical Travel
- ☐ Fire/Natural Disaster Assistance
- ☐ Funeral Travel Reimbursement
- ☐ Medical Equipment/Supplies/Furniture
- ☐ Prescription Reimbursement
- ☐ Utility Disconnect Assistance
- ☐ Medical Bills
- ☐ Catastrophic Shelter Assistance
- ☐ Dental Related Expenses
- ☐ FMLA Wage Replacement
- ☐ AODA Inpatient/Outpatient Services
- ☐ Optical Related Assistance
- ☐ Security Deposit Assistance
- ☐ Social Security Disability Determination Shelter/Utilities

APPLICANT INFORMATION

Last Name:	First Name:	M.I.	Date of Birth:
Physical Address:		Apartment/Unit #:	
City:	State	ZIP:	County:
Mailing Address:		Apartment/Unit #	
City	State	ZIP:	Tribal Affiliation:
Phone Number:	E-Mail:	Enrollment #	
Social Security #	Driver's License #	U.S. Citizen: ☐ Yes ☐ No	

Marital Status (circle one): ☐ Single/Never Married ☐ Married Living Together ☐ Married Separated ☐ Divorced ☐ Widowed

Do you live on the reservation: ☐ Yes ☐ No How long have you lived at this address:

Sex: ☐ Female ☐ Male | Are you a Veteran: ☐ Yes ☐ No | Highest grade level you completed:

Current source of income earned/unearned list all:

CO APPLICANT INFORMATION

Last Name:	First Name:	M.I.	Date of Birth:
Phone Number:	E-Mail:	Tribal Affiliation:	
Social Security #:	Driver's License #:	Enrollment #:	

Marital Status (circle one): ☐ Single/Never Married ☐ Married Living Together ☐ Married Separated ☐ Divorced ☐ Widowed

Sex: ☐ Female ☐ Male | Are you a Veteran: ☐ Yes ☐ No | U.S. Citizen: ☐ Yes ☐ No

Current source of income earned/unearned list all:

List ALL other adults in household

Full Name	Relationship	Monthly Income	Do they cost share expenses	Tribal Affiliation

CURRENT EMPLOYMENT OR SELF-EMPLOYMENT FOR ALL ADULTS IN HOUSEHOLD

Household Member Name	Employer Name/Address	Gross Monthly Amount	Current Status	Is Health Insurance offered?

CHILD INFORMATION - Please write the names of ALL children in the household

Child's Name:	D.O.B.	Social Security Number:
Relationship to Head of Household:		What School does child attend:
Tribe:	Tribal Enrollment #:	☐ Female ☐ Male US Citizen: ☐ Yes ☐ No

Child's Name:	D.O.B.	Social Security Number:
Relationship to Head of Household:		What school does child attend:
Tribe:	Tribal Enrollment #:	☐ Female ☐ Male US Citizen: ☐ Yes ☐ No

Child's Name:	D.O.B.	Social Security Number:
Relationship to Head of Household:		What school does child attend:
Tribe:	Tribal Enrollment #:	☐ Female ☐ Male US Citizen: ☐ Yes ☐ No

Child's Name	D.O.B.	Social Security Number:
Relationship to Head of Household:		What school does child attend:
Tribe:	Tribal Enrollment #:	☐ Female ☐ Male US Citizen: ☐ Yes ☐ No

CURRENT VEHICLE OWNERSHIP - Complete section if applying for auto repair

Applicant Name	Make, Model, and Year of Vehicle	Registration	Insurance Provider	How long you own?

SOURCES RECEIVING OR APPLIED FOR ALL ADULTS IN HOUSEHOLD

Type of Income	Yes	No	Recipient Name	Monthly Amount
Child Support Payments				
Caretaker Supplement				
Unemployment Insurance Comp				
SSB: Retirement, Survivors, Disability, SSI				
Retirement: Federal, State, Tribal, RR				
VA/Military Benefits				
Worker's Compensation				
Short/Long Term Disability				
Tribal Per Capita				
Insurance/Settlement/Lottery				
Self- Employment (working for cash)				

SERVICES RECEIVING OR APPLIED FOR

Does anyone in your household receive FoodShare	☐ No ☐ Yes If yes, list agency:	
Does anyone in your household receive Commodities	☐ No ☐ Yes If yes, list agency:	
Does anyone in your household receive Child Care Assistance	☐ No ☐ Yes If yes list agency:	
Does your household receive housing assistance (subsidized)	☐ No ☐ Yes If yes, list agency:	
Do you or anyone in your household have health care	☐ No ☐ Yes If yes, list provider:	
Has anyone in your household applied for Energy Assistance	☐ No ☐ Yes If yes, list agency:	
Is your household receiving W2 or TANF	☐ No ☐ Yes If yes, list agency:	

Please Provide Statement Below

You MUST describe your current crisis situation and what you are requesting from the program:

CONSENT FOR RELEASE/DISCLOSE & SIGNTURE	
I consent to release any and all information necessary for the determination of benefits to be made on my behalf, and to the Oneida Nation Economic Support Agency and Community Support. I understand this release may include, but not limited to, any information regarding income, salary, benefits, and disability. I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application will result in denial of benefits.	
Applicant Signature:	**Date**:
Co Applicant Signature:	**Date:**

OFFICE USE ONLY	
Application Status: ☐ Approved ☐ Denied ☐ Pending	
Comments:	
Staff Signature:	Date: