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
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www.oneida-nsn.gov

CommunitySupport 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 VERIFICATIONS:

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

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 applicant applied for all financial assistance offered at the medical 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

- 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

Furnace Repair/ Replacement

- Two (2) cost estimates for repair/replacement of a water heater or furnace from a licensed/certified repair professional, to include the name, address, phone number, and Federal Tax Identification number of the professional;

- Verification that the applicant applied for Energy Assistance with the county agency in which the applicant resides, along with proof assistance was denied;

-Verification that the applicant is the owner of the home;

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 applicant applied for Energy Assistance
- Verification of payments made in each of the previous three (3) months

Community Support Fund Application

CIRCLE SERVICES YOU ARE APPLYING FOR

ONEIDA

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

Auto Repair, List # vehicles in home:__
Cobra Insurance
Medical Travel
Fire/Natural Disaster Assistance
Funeral Travel Reimbursement
Medical Equipment/Supplies/Furniture
Prescription Reimbursement
Utility Assistance
Social Security Disability Determination Shelter/Utilities
Medical Bills
Catastrophic Shelter Assistance
Furnace Repair/Replacement
Dental Related Expenses
FMLA Wage Assistance
AODA Inpatient/Outpatient Services
Optical Related Assistance
Security Deposit

APPLICANT INFORMATION

Last Name:	**First Name:**	**M.I.**	**DOB:**	**SSN:**
Mailing Address:			**Apartment/Unit #**	
City:	**State:**	**ZIP:**	**County:**	
Physical Address:			**Apartment/Unit#**	
City:	**State**	**ZIP:**	**County:**	
Phone Number:		**Email:**		
Sex: (circle one): Female Male	**Marital Status (circle one): Single/never married Married living together Divorced Widowed**			
Are you a veteran: Yes No	**Highest grade attended:**	**Disabled: Yes No**	**Live on the reservation: Yes No**	
Enrollment #	**Tribal Affiliation:**			

CO APPLICANT INFORMATION

Last Name:	**First Name**	**M.I.**	**DOB:**	**SSN:**
Phone Number:	**Email:**			
Sex: (circle one): Female Male	**Marital Status (circle one): Single/never married Married living together Divorced Widowed**			
Enrollment#	**Tribal Affiliation:**			

LIST ALL HOUSEHOLD MEMBERS & INCOME TYPE (EARNED OR UNEARNED)

Full Name	DOB	Relationship	Income Type	Monthly Amount	Tribal Affiliation

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:**

Revised 2/5/2020