A good mind. A good heart. A strong fire.

Aging & Disability Services

Disability Fund Request Application

Applicant Information

Full Name: ______________________________ Date: ____________

Last *First* *M.I.*

Mailing Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

____

Physical Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ____________________ Email ____________________

Date of Birth: ___/___/___ Social Security No.: ____________ Enrollment #: ____________

Sex (circle one): **Male** **Female** Are you a Veteran: **Yes** **No** Disabled: **Yes** **No**

Caregiver/Power of Attorney Information

Full Name:		
Address:		(circle one): POA or Caregiver
Phone:		
Full Name:		
Address:		(circle one): POA or Caregiver
Phone:		

Services Requested

Please provide what type of services you are requesting, please be specific:

Disclaimer and Signature

I certify that my application is complete to the best of my knowledge.

Signature: ______________________________ Date: ______________

Please provide the following document verifications:

- Copy of Oneida Tribal enrollment card
- Proof of residency (current utility bill within last 30 days)
- Proof of disability (letter from SSA, Veterans office or medical professional)
- Denial letter(s) from other area agencies for same requests above

****ALL REQUESTS WILL BE RESPONDED TO WITHIN TEN (10) BUSINESS DAYS****

FOR OFFICE USE ONLY

(circle one): **APPROVED** **DENIED**

Completed by: ______________________________

Costs of request: ______________________________

Date completed: ______________________________