ELDER SERVICES PROGRAM APPLICATION FY 25-26

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D/A	
SIGN	

Name: _____

Enrollment #:_____DOB:_____AGE:_____

Mailing Address:_____

Physical Address: _____

Phone: _____ Cell / Message: _____

Emergency Contact Name:_____Number:_____

OTHERS LIVING WITH YOU (spouse, children, other family, friends)

Name	Enrollment Number	Age	Income (Yes/No)	Relationship

Are you on Trust/Fee land? Do you live in Rural area/City limits?
Have you applied for LIHEAP? _____ What is your main source of heat? _____
What services are you requesting?

_____

_____

Please circle Y/N for each item and include income for all persons in the household.

Disabled	Y N	Medicaid	Y N	Home Owner	Y N	Wages	$
Diabetic	Y N	Medicare Part A Part B Part C	Y N	Home-Owners Insurance	Y N	(circle all that apply) SSI SSDI	$
If yes, are you on Diabetic Program at THHS?	Y N	Other Insurance	Y N	Landlord, if renting Name & Phone #	Y N	TANF	$
Ever used the Elders Program before? When?	Y N	Champus/ TriCare /Veterans	Y N	Social Security #		NO INCOME (Declaration needs to be signed)	
Do you feel safe in your home? Explain:	Y N	Release of Information Needed for help with Medical or Social Security issues	Y N	Food Stamps Commodities	Y N Y N	SELF EMPLOYED	$

WHEN YOU SIGN THIS FORM, YOU ARE STATING THAT THE INFORMATION PROVIDED IS TRUE AND ACCURATE AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Signature: _____ Date: _____

Confederated Salish and Kootenai Tribes
Department of Human Resource Development
Elder Services Program
PO Box 278
Pablo MT 59855
406-675-2700 ext. 1063/1139 Office
406-226-2699 Fax

A People of Vision

The Department of Human Resource Development administers the Elder Services Program. We will make every effort to assist you, but please read the following before completing your application.

PLEASE READ

The Elder Services program was established to assure our Elder Tribal Members would not be without essential services including but not limited to; home, health and basic needs.

Eligibility is 60 years of age and an **enrolled member of the CSKT**, or you must be at least 55 years of age with a documented disability. Please submit all income verification, Proof of Ownership and Proof of CSKT enrollment. **ALL INFORMATION WILL BE VERIFIED.**

All requests will be evaluated and answers will be given to the Elder as soon as possible after the request is received. In some cases, additional information may be required.

In an effort to assist you, we may ask you to fill out other applications and provide additional verifications, if we believe you may qualify for other sources of assistance. Therefore, we ask for your patience and understanding while we process your request and try to assist you.

Thank you for your understanding and patience.

No-Income Declaration

Signature of any household member, 18 years or older, declaring no income:

NAME OF EACH INDIVIDUAL

LIST MONTH(S) YOU DID NOT HAVE INCOME:

1) I, _____, do hereby declare that for the months of: _____ _____ _____
2) I, _____, do hereby declare that for the months of: _____ _____ _____
3) I, _____, do hereby declare that for the months of: _____ _____ _____
4) I, _____, do hereby declare that for the months of: _____ _____ _____

Please explain how household expenses were met (i.e. rent, mortgage, food, childcare, utilities, car maintenance, and car insurance, other):

_____

_____

_____

_____

I/We have not received any income, from any source. I/We declare by signing the above statement line that the information provided on this form is true and correct to the best of my/our knowledge. I understand that because the Elder's Services Program is federally funded, the penalty for providing false information shall not be more than a $10,000 fine and/or not more than five (5) years imprisonment.

Date:_____ Individual claiming no income:_____
Date:_____ Individual claiming no income:_____
Date:_____ Individual claiming no income:_____
Date:_____ Individual claiming no income:_____
Date:_____ Head of Household:_____

Confederated Salish and Kootenai Tribes
INTERAGENCY
CONSENT FOR RELEASE OF INFORMATION

I/We, the undersigned are seeking services from the Department of Human Resources Development (DHRD) which includes, but is not limited to the following programs: Child Care Block Grant, TFAP Cash Assistance, Commodities, Dire Need, WIA, SYEP, LIHEAP, NEW, Welfare 2 Work, General Assistance, FEMA, Indian Elderly Program, Vocational Rehabilitation Program, and WIC.

I/We, authorize the above-named programs to share, exchange, give and receive information about my application and contents therein, in an effort to serve me, my family and my children (as declared on my application/applications for assistance).

In addition, I/We authorize the following programs/agencies to release and share information to the DHRD Program in an effort to provide and facilitate assistance to my/our children and myself/ourselves. Those programs and agencies include but are not limited to the following: **INITIAL EACH DEPT. YOU AUTHORIZE TO RELEASE INFORMATION.**

1._____Tribal Personnel Office: (Drug Test Results), etc.
2._____ Early Childhood Services – ECS – Participation in services (CHIP information, Address, Household Composition)
3._____ Tribal Health and Human Services – THHS (Mental Health, Family Support, Alternate Resource), etc.
4._____ Tribal Education Department – TED (educational awards, grants, referrals), etc.
5._____ Salish Kootenai College/ALC/ABE Programs – (Schedule, test results, Student verification of attendance, Credit Loan, Grants), etc.
6._____ Montana State Offices of Public Assistance – (Flathead, Lake, Missoula, Sanders County)
7._____ Salish Kootenai Housing Authority – SKHA (Rent amount, household compositions, lease compliance, residency), etc.
8._____ S&K Holding – Welfare to work issues
9._____ Public Schools – (verify attendance of minor children in general school and at IEP sessions)
10._____ Tribal Police – (CPS referrals and outstanding warrants), etc.
11._____ Probation Adult/Juvenile – (Truancy, Community services and other requirements)
12._____ Tribal Court – Community Services and Court Orders, etc.
13._____ Division of Lands – (verify Land Lease), etc.
14._____ Tribal Prosecutors/Tribal Defenders (CPS, Court Orders, Truancy, Families at Risk Staffing), etc.
15._____ MT Children's Health Insurance Program (CHIP) – Eligibility Status & Employee Health Insurance Information
16._____ Tribal Enrollment – verify enrollment – Enrolled Tribe:_____
17._____ Social Security Administration, MT Disability Bureau, Veteran's Administration – Verify income
18._____ Workman's Compensation Programs (income verification, medical coverage)
19._____ Tribal Credit (mortgage or escrow for ownership)
20._____ Other:_____

I/We understand that the information received by the DHRD Programs will be kept confidential, used for professional purposes only in terms of facilitating services received by me and my/our family, and will not be released to other outside programs/agencies, unless prior authorization by me, in writing, is obtained. I/We understand that I/We may cancel this Consent for Release of Information, in writing at any time.

_____ _____
Print Name – Applicant/Parent or Guardian Date Sign Name Date

_____
Witness Date

THIS CONSENT FOR RELEASE OF INFORMATION IS VALID FROM _____ TO _____

THIS RELEASE OR REQUEST OF INFORMATION HAS BEEN REVOKED BY:

_____ _____
Applicant/Parent or Guardian Signature Date