Little Traverse Bay Bands of Odawa Indians
Elder's Program
Direct Client Services Program

Name _____ Enrollment # _____

Address _____ Birth date _____

City _____ State _____ Zip _____ Phone _____

Other persons living in household

	Name
1.	
2.	
3.	
4.	
5.	

I am in need of assistance because: (please complete below)

Vendor information:

Vendor Name	
Complete Mailing Address	
Your Account Number	

- I understand that I can apply only once per 12 month period for assistance
- I hereby certify that all information in this application is true, correct and complete to the best of my knowledge.
- I understand that giving false or incomplete information can result in referral to the prosecuting attorney for fraud, and/or recovery of funds paid on my behalf.
- I understand that failure to provide all necessary information and documentation can result in denial of my application
- I understand that I have the right to a hearing if I do not receive a decision notice within that time.
- I understand that there is no guaranteed payment towards my bill until my application has been approved and a decision notice sent to me.
- Please include copy of Tribal ID

Applicant's Signature _____ Date _____

Elder's Program Signature _____ Date _____

Documentation Checklist-Office use only do not write below this line

☐ Completed application
☐ Tribal ID
☐ Denial Letter
☐ W-9
☐ Estimate
☐ Invoice
☐ Income Verification

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