Little Traverse Bay Bands of Odawa Indians

7500 Odawa Circle
Harbor Springs, MI 49740
Phone: (231) 242-1620
Fax: (231) 242-1635

Burial Assistance Application

Please print

Requestor

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone # _____

	Name	DOB	Social Security Number	Tribal Number
Deceased				
Father				
Mother				

Residence Information

Address _____

City _____ **State** _____ **Zip** _____

Funeral Home (if applicable)

Name _____

Director _____

Address _____

City _____ **State** _____ **Zip** _____

Phone # _____ **Fax #**

- ❑ I am requesting assistance for the burial costs of my family member.
- ❑ I understand that the citizenship status of the deceased person shall be verified before any burial funds can be processed.
    - o If request is for a child less than one (1) year of age eligibility for citizenship shall be verified before any burial funds can be processed.
- ❑ I understand that there is a six (6) month statutory time limit for submission of original invoices and/or receipts, including but limited to the following expenses:
    a. Funeral Services/Funeral Director Fees
    b. Cosmetics for burial process
    c. Casket or other container
    d. Cremation or embalming expense
    e. Cemetery and/or ground opening expense
    f. Grave Markers
    g. Floral arrangements
    h. Transportation of deceased: (Funeral home to cemetery, etc)
    i. Clergy or officiate
    j. Drum/Pipe Carrier/Music/Spirit Medicines
    k. Catering
    l. Food or supplies for feasts or ceremonies
    m. Guest books
    n. Photos/Photo albums
    o. Printing
    p. Or other similar expenses
- ❑ I understand that I must provide an original death certificate to the Little Traverse Bay Bands of Odawa Indians Human Services Department.
- ❑ I understand that I must provide original receipts for any paid expenses associated with burial costs.
- ❑ I understand that I am required to return a W-9 Form for all person's requiring payment for the above services and/or supplies.

_____ _____

Signature of Requestor Date

For Office Use Only—
This section will be completed by Human Services.

Date Requested Received:_____ 6 Month Time Limit:_____

Citizenship Verified:_____ Requested: Approved____ Denied____

Amount of Assistance:_____ Reason for denial_____