



**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 # _____ Email Address _____

	Name	DOB	Tribal Number
Deceased			
Father			
Mother			

Residence Information

Address _____

City _____ State _____ Zip _____

Funeral Home (if applicable)

Name _____

Director _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

**BURIAL ASSISTANCE
APPLICATION**

- 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.
 - 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 _____