

## **MATCH-E-BE-NASH-SHE-WISH BAND OF POTTAWATOMI INDIANS**

### **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

#### **Emergency Needs Assistance Program**

##### **I. Policy**

The Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians will operate an Emergency Assistance Program for tribal members and users of service that are determined income eligible.

##### **II. Date Enacted**

Reviewed and passed through Health and Human Services Committee on July 7, 2004.

##### **III. Purpose**

- A. To provide assistance to tribal families and individuals who meet the minimum standard of 125 percent of poverty level. (Attachment A)
- B. To address the most basic and immediate needs of low-income people, which will assist them in making better use of their available income, assist in obtaining and maintaining suitable living environments, provide emergency assistance grants for energy, medical prescriptions, transportation to medical appointments, housing needs or assist individuals when finding meaningful employment, assist students needing school clothing, or school supplies.

##### **IV. Program Description**

- A. The program will consist of the following components, as stated in the guidelines of the Community Services Block Grant, administered by the Inter-Tribal Council of Michigan Inc
  - 1. Emergency Food Assistance (\$150)
  - 2. Emergency Housing Assistance (\$400)
  - 3. Emergency Energy Assistance (\$300)
  - 4. Emergency Assistance for Prescriptions (\$200)
  - 5. Transportation for medical and dental services (\$150)
  - 6. Emergency clothing or clothing assistance to obtain employment (\$80)
  - 7. Emergency clothing for families in cases of fire or low-income students needing assistance with clothing and/or school supplies (\$200)
  - 8. Clothing for foster children (\$125)

## V. Eligibility

- A. A client is determined eligible for services when:
1. They have attained the age of 18 years of age and are enrolled member of the Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians.
  2. They are the parent or legal guardian of an enrolled member who has not reached 18 years of age.

## VI. Procedures

- A. The Health and Human Services Department must receive a completed application (Attachment B) signed by the applicant to begin processing any request for assistance. The Human Services Coordinator shall follow up on all incomplete applications to assist in finalizing the application.
- B. The Emergency Needs Program is designed to provide limited, one time service to applicants, per grant cycle. The program is not intended to and may not provide complete coverage of expenses. The applicant may request assistance from more than one component: Total monetary services will **not exceed \$400 per individual or family**.
- C. Emergency needs funds cannot be accessed until all other county and tribal services that are related to the request have been utilized. An applicant must provide a bill or invoice for services to be rendered or goods to be purchased.
- D. An applicant may receive direct payment. The applicant must file a receipt showing payment by the applicant within ten days of receiving the funds. **Failure to submit a receipt within the time frame allowed will result in the applicant being prohibited from utilizing this or other tribal programs in the future.**
- E. Final processing of the request will occur when the Health and Human Services Department has received all required documentation and a completed application. Application will be processed and applicant notified within five working days.

\_\_\_\_\_  
Client's Initials

*Documentation is considered: Tax forms, FIA case information, Disability or Social Security information, a letter of referral from other county and/or tribal programs. Applicant must be in good standing with all other tribal programs.*

- F. **NO expenses related to this program shall be utilized to purchase alcohol, tobacco products, or for the purchase of illegal substances. Any applicant receiving assistance, which is subsequently identified as an expense derived from a prohibited expense or criminal activity shall result in the applicant being prohibited from accessing this program in the future.**

\_\_\_\_\_  
Client's Initials

**VII. Maintenance of File**

- A. Files for the Emergency Needs Program will be maintained in a confidential filing system and shall not be released without written consent (Attachment C) of the applicant, except as stated below:
  - 1. **Statistical-** Information may be compiled and reported to internal or external agencies. Information will not contain any specific identification or applicant.
  - 2. **Program Building-** Information may be compiled and shared to the extent necessary to identify a need to expand or create a program. Information will not contain any specific identification of applicant
  - 3. **Multidisciplinary Teamwork-** Caseworkers shall notify the applicant of multidisciplinary teamwork, which may not be waived, forfeited, or rejected.

\_\_\_\_\_  
Client's Initials

**VIII. Disbursement of Funds**

- A. Applicant will submit a completed application, which will be reviewed by the Human Services Coordinator, if the request is less than One Hundred Dollars (\$100) or by the Health and Human Services Committee, if the request is more than One Hundred Dollars (\$100). If the Health and Human Services Committee is not scheduled to meet, a phone poll of the committee will be conducted.
- B. Once the application has been accepted, a finance voucher (Attachment D) will be completed and submitted to the MBPI finance office for processing.
- C. The finance office will process the request as a priority (within 24 to 48 hours). If payment is to a vendor, payment will be mailed from the finance office. If payment is to applicant, then the Human Services Coordinator will contact applicant.

**CERTIFICATION**

I have read the policies for the Emergency Needs Assistance Program, and I understand the eligibility requirements and have initialed in the designated areas. By signing this, I am verifying that I meet the requirements and agree to abide by the program policies.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Authorization**

\_\_\_\_\_  
**Date**

**MATCH-E-BE-NASH-SHE-WISH BAND OF POTTAWATOMI INDIANS  
COMMUNITY SERVICES BLOCK GRANT  
EMERGENCY NEEDS PROGRAM  
FISCAL YEAR 2009 APPLICATION**

Name:		Age:	Date:
Address:		Birthdate:	Social Security Number:
City/Town	State:	Zip Code:	Phone Number:

**TRIBAL MEMBER OF:**

\_\_\_\_\_ Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians      Enrollment #: \_\_\_\_\_

**OTHER HOUSEHOLD MEMBERS:**

NAME:	AGE:	BIRTHDATE:	SOCIAL SECURITY NUMBER:
1.			
2.			
3.			
4.			
5.			
6.			

Have you applied for assistance this year (October 1, 2008 –September 30, 2009)?      Yes      No

**(FOR OFFICE USE ONLY)**

**INCOME: Documentation must be provided for all income.**

Name:	Income Code Source	Past 30 Days Income	X 12 = Annualized Income

**INCOME SOURCE CODES: (Please Circle)**

1. SS      2. Wages      3. SSI      4. Self Employment      5. Unemployment  
6. ADC      7. GA      8. Pension/Retirement      9. Other \_\_\_\_\_

- 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 hereby authorize the release of information by the appropriate agencies to Match-E-Be-Nash-She-Wish Band of Pottawatomi Human Services for the purpose of verifying information needed to establish eligibility for the program.**
- I understand that I may request a hearing if I disagree with action taken on this application.
- I understand that I have a 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.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
ENP Worker's Signature

\_\_\_\_\_  
Date

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**REFERRALS:** Your household may be eligible to receive assistance through the following list of programs offered by your local DHS, Community Action Agency, and/or utility company.

**Contact them for more information on:**

- Weatherization
- Emergency Needs
- Utility Shut Off Protection
- Home Heating Tax Credit
- Energy Audit

**“0” Income Form**

To determine your eligibility for the Community Services Block Grant/Emergency Needs Program you must furnish proof of all household income for the past 30 days prior to the date of your application.

If you had “0” income for the past 30 days, you must answer the following:

1. What was your income for the past three (3) month? (Please include amount and source of income for all household members 18 years of age and older).

Name:	Source:	Amount:

2. If you have utility bills, how do you pay them?

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3. How do you pay your rent?

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4. How do you get food for your household?

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I hereby certify that the information detailed above represents my household’s circumstances. The income listed is the total household income for each household member 18 years of age and older.

\_\_\_\_\_  
Applicant’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
ENP Outreach Worker’s Signature

\_\_\_\_\_  
Date