

# UMU TRIBAL EMERGENCY ASSISTANCE REQUEST FORM MEDICAL FY 2024

Tracking Number: \_\_\_\_\_ Date of Request: \_\_\_\_\_  
Phone No: \_\_\_\_\_

Member Name: \_\_\_\_\_ Census Number: \_\_\_\_\_ Amount: \_\_\_\_\_

Purpose/Supporting  
Doc.(Attach): \_\_\_\_\_

Type of Assistance: Medical

**Certification of need: I hereby certify that this request is based on extraordinary need. I have sought assistance from all other sources of funds available to me prior to this request, but all of those sources are exhausted or unavailable to me at this time. I understand that emergency assistance will be provided only if the assistance is applied pursuant to all program guidelines in effect for this legislatively authorized tribal social benefit program. I also understand that failure to return payments that do not satisfy all program guidelines will result in a denial of future benefits. Benefits that do not meet all requirements under the Weenuche Assistance Act must be repaid. Misuse of assistance may also be reported as taxable income. By signing this application, I authorize repayment of any improper benefits through payroll deduction or offset of future benefits, assistance or other payments from the Tribe.**

**If my family income is above the Tribal Income guidelines, I request assistance based on the following additional facts and circumstances demonstrating my extraordinary financial burdens:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Sig. of Member/Parent or Guardian                      Employer                      Signature of Employer

### Member Services Department Review

Satisfies Facts & Circumstances Extraordinary Need                       Does not Satisfy Facts & Circumstances  
Extraordinary Need

Authorization: \_\_\_\_\_ Compliance Review: \_\_\_\_\_

### For Declined Assistance Requests

Council Approval to Charge to their Budget

Authorization: \_\_\_\_\_ Approved

\_\_\_\_\_  
Signature  
Councilman