

UMU TRIBAL EMERGENCY ASSISTANCE REQUEST FORM MEDICAL FY 2025

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

Authorization: _____ Council Approval to Charge to their Budget
Approved

Signature
Councilman