COMMUNITY NEEDS ASSISTANCE PROGRAM (CNAP) APPLICATION FY2024

CAP Office, 16429 Bear Town Road, Baraga, MI 49908
Phone:(906) 353-4162 Fax: (906) 353-4179

***REQUIRED: ATTACH A COPY OF YOUR TRIBAL ID AS PROOF OF RESIDENCY, WITH YOUR CURRENT ADDRESS.**

APPLICANT	PHONE #	REQUEST DATE
ADDRESS	COUNTY	ENROLLMENT#

NON-MEDICAL EMERGENCY ASSISTANCE (*Funding up to **$500** per fiscal year for each household*).

$_____ Amount Requested – Please check which type of request below:

[_____] Home Repairs/Replacement of Appliances/Equipment (attach estimate or receipt).

[_____] Utility/Heating Disconnection Assistance (attach utility shut off/disconnect bill and amount due).

[_____] Vehicle Repair or Tire Replacement (attach estimate/receipt, current registration and insurance).

[_____] Travel for significant life's event – Graduation from College/University, Military/Police Academy

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ADDITIONAL ASSISTANCE (*Additional funds are available with Tribal President Approval*).

[_____] Fire or Flood Assistance – For fire or flood damage involving a primary residence up to $1000.00.

[_____] Out of the Area Funeral Travel: up to **$200** for immediate family member funeral travel **per household.**

MEDICAL TRAVEL/SERVICE ASSISTANCE *(Request up to $600 per fiscal year. Additional funds available for eligible applicants with chronic illness/conditions.)*

Do you receive medical travel assistance from Medicaid (UPHP), Veterans Affairs, Medical Transport Services, Healthy Start, Insurance, Workman's Comp. or any other agency: [_____] NO [_____] YES

If yes, you must provide a denial along with this request.

Please check which type of Medical Travel Assistance being requested below:

[_____] Medical Travel Specialists **[_____]** Overnight Hospitalizations

[_____] Medical/Surgical Procedures **[_____]** Out of Area Travel to Visit Hospitalized Immediate Family

[_____] Medical Alert Services **[_____]** Sobriety/Family Therapy Sessions

***REQUIRED: ATTACH VERIFICATION OF APPOINTMENT(S) PROCEDURE(S) WITH PATIENT'S NAME, DATE AND TIME OF APPOINTMENTS, THE LOCATION AND LENGTH OF STAY.**

Specify in detail your type of request: ***(Include travel dates, times; location; lodging; food assistance; and if a driver is needed, etc.).***

I hereby request assistance and I hereby authorize the release of information for myself or any other member in my household, in order to obtain information (including medical), specific to the KBIC CNAP application and related request.

For medical requests, I agree to turn in verification of attendance, hotel receipts, and/or travel fund overages, within five (5) business days. I understand that I will not receive future CNAP funding until the total amount of medical travel overages are paid in full.

Applicant/Head of Household Signature_____ ***Date***_____

SHADED AREA FOR OFFICE USE ONLY

[_____] Approved – Recipient_____ $_____Amount

[_____] Denied – Reason _____

*CAP Administrator*_____ *Date*_____

You have a right to file an appeal for denials. Hearing process sheets can be obtained in the CAP office.

CAP HOUSEHOLD APPLICATION FY2024

16429 Bear Town Road, Baraga, MI 49908, Phone: (906) 353-4162, Fax: (906) 353-4179

Head of Household _____

Social Security # _____ **Age** _____ **Date of Birth** _____**Tribal ID#** _____

Physical Address _____

Enrollment Card required to apply for assistance (address must be current and updated with KBIC Enrollment Office).

Mailing Address_____

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

Are you currently homeless? ☐ **YES** ☐ **NO** **Phone/Cell** _____

List of Household Members ***(Place a star * next to members who are attending college or in the service, etc.)***

LAST NAME	*FIRST NAME*	*RELATION TO HEAD OF HOUSEHOLD*	*DATE OF BIRTH*	*AGE*	*TRIBAL ID#*

Household Applicant Declaration

I agree to report changes in my household composition as they occur and I agree to report an address change and update with enrollment as required, to be eligible for CAP assistance.

I hereby authorize the release of information for myself or any other member in my household, in order to obtain information (including medical), specific to the Community Assistance Program application and related request.

I hereby certify that the above information of the household composition is correct and completed to the best of my knowledge and may be used for the purpose of verification when determining eligibility.

Head of Household _____ **Date** _____