



Confederated Tribes of the Chehalis Reservation



Social Services

Household Assistance Policy

Household Emergency Assistance Application

Incomplete applications will not be processed. Please attach all required information.

Please Check: ☐ First Assistance ☐ Second Assistance ☐ Unknown

Applicant Information

Tribal Member Name (Applicant): _____

Enrollment Number: _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Preferred Method of Contact (circle one): _____

Household Information

Number of people living in the household: _____ *(If more room is needed, include names in the blank area to the side.)*

List all household members (Name & Date of Birth):

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____
6. _____ DOB: _____
7. _____ DOB: _____
8. _____ DOB: _____

Type of Assistance Requested *(please check one box only. If more than one is checked, it will count as **both** assistances for the year.) If utilities, rent or mortgage is checked, please ensure proper documentation is attached)*



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☐ Basic Needs Voucher (Food, Clothing, and Household Necessities)

☐ Utilities (electric, gas, heat source)

☐ Rent / Mortgage

Vendor Information (if applicable)

Vendor Name: _____

Account / Invoice Number: _____

☐ Invoice attached

☐ W-9 and Vendor Form attached (if not already on file)

Applicant Certification & Receipt Agreement

I certify that the information provided on this application is complete and accurate to the best of my knowledge. I understand that providing false information may result in denial of assistance, repayment of funds, and/or criminal prosecution.

I agree to submit all required receipts to the Social Services Department within thirty (30) days of receiving assistance. I understand that no additional vouchers will be issued until all required receipts have been received and verified.

I further understand that if more than two (2) vouchers are requested, I may be required to participate in financial literacy classes prior to receiving additional assistance, contingent upon program funding and availability.

I authorize the Social Services Department to verify information with other Tribal programs as necessary.

Applicant Signature: _____

Date: _____

SOCIAL SERVICES USE ONLY

Staff Notes:

Assistance Issued: ☐ Yes ☐ No

Type: _____

Amount Issued: \$ _____



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Assistance Number ☐ One ☐ Two ☐ Financial Agreement

Staff Name (Print): _____

Staff Signature: _____ Date: _____