

BEAR RIVER BAND of the ROHNERVILLE RANCHERIA

266 KEISNER RD LOLETA, CA 95551-9707

PHONE 707-532-0254, (707)733-1900 ext.1012, FAX 707-733-1723



Tribal Benefits Application

Applicant/Guardian Information

Name: _____ Enrollment Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Type of Benefit Service Requested:

Clothing Assistance-

6240-002-055-00

- Adult Work Minor School
- Youth Employee Infant Elder

Dental Assistance- 6250-002-055-00

Elder Utility Asst. - 6100-002-069-00

Funeral Assistance- 6960-002-055-00

Household Assistance- 6261-002-055-00

Prescription RX Asst. - 6250-002-069-00

Pediculosis (Lice) Asst. 6110-002-055-00

Minor Trust Fund- 1250-000-000-00

Education *Medical* - Date: _____

LIHEAP-Supplement-6100-002-055-00

Out of Area Medical Travel

6120-002-055-00 Travel Date: _____

Out Of Area Family Assistance-

6120-002-055-00-Appointment Date: _____

Sports and Recreation- 6425-002-055-00

- Adult Minor

Cultural Assistance- 6110-076-000-00

Material/Event: _____

Basic Needs Assistance \$150.00

Food Card - 6420-002-055-00

Winco *Grocery Outlet* *Costco*

Receipt Initial: _____

Utility - 6100-002-055-00): _____

Amount Past Due:

\$ _____

Holiday Box/Card 6420-002-004-99

- Thanksgiving Christmas

Explain the requested assistance and provide any additional information needed to process your request:

Child Information (If the child is the beneficiary) must be fully completed

Name: _____ DOB: _____ Enrollment #: _____

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Submit all signed applications in person to the Benefits Coordinator, or fax to (707) 733-1723, or email to benefits@brb-nsn.gov, or mail to 266 Keisner Rd. Loleta, CA 95551. Questions: Please call (707) 532-0254. Benefit Applications (Including food cards) will be processed within 3-7 days. Benefit Applications must be fully complete in order to be processed.

I understand that my assistance and related charges will be applied as set forth in referenced policies.

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I further acknowledge that this information is subject to verification and that falsification of such information shall be grounds for my termination from any program which I am participating or eligible for. I am aware that if receipts are NOT submitted within 30 days it will be deducted from future per capita.

Applicant/Guardian Signature _____ Date: _____

Benefits Coordinator Signature: _____ Date: _____

OFFICE USE ONLY

Vendor: _____ Amount: \$ _____

Reimbursement Financial Support Food Card -Winco GOutlet Costco

DC/CC Charge: # _____ Date: _____