



# Tribal Extended COVID-19 Public Assistance Program

EASTERN BAND OF THE CHEROKEE INDIANS COVID-19 RESPONSE

## **EMERGENCY SERVICES: COVID-19 Financial Assistance**

EBCI may provide short-Term benefit, as funds permit, to a family whose household income has been reduced because of the COVID-19 outbreak. This financial assistance will be provided from the EBCI's allocation of funding under the CARES Act. Extended COVID-19 benefits may be available to any enrolled member living of the Eastern Band of Cherokee Indians. Needy for purposes of Extended COVID-19 benefits means families with incomes up to 300% of poverty level. To qualify for Extended COVID-19 benefits, the family must have an episode of need, such as loss of income due to the current disaster.

### Qualification Requirements

1. Applicant must have at least one enrolled member in the home
2. Applicant must be below 300% of the Federal Poverty Level (FPL) in the month of application  
**OR** be 60 years of age or older at any income level
3. A single pregnant woman in her third trimester may also apply
4. You must provide proof of layoff, unemployment, or other COVID-19 impact on the household that includes the following:
  - a. Loss of employment due to COVID-19
  - b. Unable to find employment due to COVID-19
  - c. Reduced hours and pay due to COVID-19
  - d. Reduced household income due to COVID-19
  - e. Increased household expenses due to COVID-19
  - f. Required to Isolate/quarantine due to COVID-19
  - g. Provided care to another due to COVID-19
  - h. Required care due to COVID-19
  - i. Unable to care for self or household due to COVID-19

Benefits would be paid once a month, as funds permit, through December 31, 2020. Extended COVID-19 benefits will be issued at the rate of \$300.00 per person in the household.

Federal Government stimulus checks will not count toward your monthly income.

Cases will be reviewed on a monthly basis.

Current TANF clients will be entitled to Extended COVID-19.



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**All Applicants must provide the following information:**

- Tribal Enrollment Cards or Certificate of Enrollment *for all household members*
- Social Security Cards *for all household members*
- Valid Driver's License or State Issued Identification Card
- Proof of all household income for the past 30 days  
*(Including Unemployment Insurance Benefit (UIB) – Verification of application, approval, or denial)*
- Unborn Child Doctor's Statement Verifying 3<sup>rd</sup> Trimester (if applicable)
- Applicant must provide proof of loss of employment due to COVID 19 to qualify for these services:
  - a. Loss of employment due to COVID-19
  - b. Unable to find employment due to COVID-19
  - c. Reduced hours and pay due to COVID-19
  - d. Reduced household income due to COVID-19
  - e. Increased household expenses due to COVID-19
  - f. Required to Isolate/quarantine due to COVID-19
  - g. Provided care to another due to COVID-19
  - h. Required care due to COVID-19
  - i. Unable to care for self or household due to COVID-19
- Application Complete with Signatures and Dates**

**YOU MAY PROVIDE INFORMATION BY EMAIL TO [sandcloe@nc-chokeee.com](mailto:sandcloe@nc-chokeee.com)  
PLEASE CALL 828-497-4317 IF YOU HAVE QUESTIONS.**

1526 Acquoni Rd • PO Box 427 • Cherokee, NC 28719  
Telephone: (828) 497-4317 • Fax: (828) 497-5736

**Tribal Extended COVID-19****Public Assistance Program****APPLICANT INFORMATION**

Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date:
Physical Address:		Mailing Address:		
City:	State:	Zip:		
County:	Do you live on the Qualla Boundary: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Tribal Enrollment:	Race:	Date of Birth:		
Social Security Number:	Do you live in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		Driver's License Number/State	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Phone Number:		Message Number:	
Have you ever received TANF before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, when and where?		
How are you related to the children on the application? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Kinship Placement				
Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please list:		
Conviction:	Year:	Conviction:	Year:	
Conviction:	Year:	Conviction:	Year:	
Are you currently on probation or parole? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please list:		

# Tribal Extended COVID-19

## Public Assistance Program

### CO-APPLICANT INFORMATION

Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date:
Physical Address:				
City:	State:	Zip:		
County:	Do you live on the Qualla Boundary: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Tribal Enrollment:	Race:	Date of Birth:		
Social Security Number:	Do you live in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	Driver's License Number/State		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Phone Number:	Message Number:		
Have you ever received TANF before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, when and where?			
How are you related to the children on the application? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Kinship Placement				
Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please list:			
Conviction:	Year:	Conviction:	Year:	
Conviction:	Year:	Conviction:	Year:	
Are you currently on probation or parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please list:			

Tribal Extended COVID-19				
Public Assistance Program				
CHILD INFORMATION				
Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Social Security Number:	Tribal Enrollment ID #:		US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School:	Grade:	Relationship to Head of Household		
List any special needs the child may have:				

CHILD INFORMATION				
Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Social Security Number:	Tribal Enrollment ID #:		US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School:	Grade:	Relationship to Head of Household		
List any special needs the child may have:				

CHILD INFORMATION				
Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Social Security Number:	Tribal Enrollment ID #:		US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School:	Grade:	Relationship to Head of Household		
List any special needs the child may have:				

# Tribal Extended COVID-19

## Public Assistance Program

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Social Security Number:	Tribal Enrollment ID #:	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
School:	Grade:	Relationship to Head of Household		
List any special needs the child may have:				

### CHILD INFORMATION

Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Social Security Number:	Tribal Enrollment ID #:	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
School:	Grade:	Relationship to Head of Household		
List any special needs the child may have:				

### CHILD INFORMATION

Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Social Security Number:	Tribal Enrollment ID #:	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
School:	Grade:	Relationship to Head of Household		
List any special needs the child may have:				

<b>Tribal Extended COVID-19</b>
<b>Public Assistance Program</b>
<b>CENTER FOR SELF-SUFFICIENCY</b>
PLEASE LIST ALL PERSONS IN YOUR HOUSEHOLD

FULL NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	INCOME AMOUNT & SOURCE	NATIVE AMERICAN	INCLUDED IN GRANT
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO

<b>INCOME INFORMATION – MONTHLY</b>	
<input type="checkbox"/> Employment      \$	<input type="checkbox"/> Child Care Assistance    \$
<input type="checkbox"/> Unemployment    \$	<input type="checkbox"/> Housing Subsidy        \$
<input type="checkbox"/> Social Security    \$	
<input type="checkbox"/> SSI Disability      \$	<input type="checkbox"/> Commodities            \$
<input type="checkbox"/> Retirement         \$	<input type="checkbox"/> Worker's Comp/L&1    \$
<input type="checkbox"/> VA/Military        \$	
<input type="checkbox"/> Food Stamps        \$	
<input type="checkbox"/> Child Support       \$	
<input type="checkbox"/> Per Capita          \$	<b>Total Income        \$</b>

<b>RESOURCES</b>			
<b>TYPE OF RESOURCE</b>	<b>WHOSE IS IT?</b>	<b>WHERE?</b>	<b>AMOUNT</b>
Checking Account			\$
Savings/Credit Union Account			\$
Other accounts			\$
Per Capita Payments			\$
Property			\$
Life Insurance			\$
Insurance claims/Settlements within last 90 days			\$
Stocks/Bonds			\$
Trusts			\$

<b>APPLICANT EMPLOYMENT HISTORY INFORMATION</b>				
Begin listing most recent employment				
<b>EMPLOYER NAME</b>	<b>EMPLOYER ADDRESS</b>	<b>POSITION</b>	<b>DATES</b>	<b>WAGES</b>
1.				
2.				
3.				
4.				

<b>CO-APPLICANT EMPLOYMENT HISTORY INFORMATION</b>				
Begin listing most recent employment				
<b>EMPLOYER NAME</b>	<b>EMPLOYER ADDRESS</b>	<b>POSITION</b>	<b>DATES</b>	<b>WAGES</b>
1.				
2.				
3.				
4.				

**CONSENT FOR RELEASE/DISCLOSURE & SIGNATURE**

I have read or had explained to me my rights and responsibilities in applying for Extended COVID-19 Public Assistance Program. I understand 1 Family Services may help me obtain the required proof or contact other persons or agencies for necessary documents. I further understand and agree that I may be criminally prosecuted if I incorrectly receive cash assistance if I have provided false or misleading information or fail to report information needed for my case. If applying for cash assistance, all adult members in the household must sign the application. I consent to release any and all information necessary for the determination of benefits to be made on my behalf, to 1 Family Services. I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application or interview may result in denial of benefits.

Applicant Signature:	Date:
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Print Name
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Co-Applicant Signature:	Date:
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Print Name
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Caseworker Signature:	Date:
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**OFFICE USE ONLY**

Amount \$	Payment Used For:
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CASEWORKER COMMENTS: <hr/> <hr/> <hr/>
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