Please Check the <u>Grant</u> requested	
Hearing Aid Grant ☐	Mental Health Grant ☐
Substance Abuse Grant ☐	

Personal Information

Full Name of Applicant	II, III, Jr. or Sr.
Mailing Address	City, State

Street Address	Zip Code	County

Home Phone Number	Work Phone Number	Tribal I.D. Number
Birth Date	Sex (circle) Female or Male	District of Residency

Mental Health Grant	Amount Requested $_____
Substance Abuse Grant	Amount Requested $_____
Hearing Aid Grant	Amount Requested $_____

I HEREBY CERTIFY THAT ALL INFORMATION IN THIS APPLICATION IS TRUE, CORRECT AND IS COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT GIVING FALSE OR INCOMPLETE INFORMATION CAN RESULT IN REFERRAL TO THE PROSE-CUTING ATTORNEY FOR FRAUD, AND/OR RECOVERY OF FUNDS PAID ON MY BEHALF AND/OR EXCLUSION FROM THE HEALTH ASSISTANCE PROGRAMS FOR A PERIOD OF ONE YEAR.

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION BY THE APPROPRIATE AGENCIES TO THE SAGINAW CHIPPEWA INDIAN TRIBE, FOR THE PURPOSE OF VERIFYING INFORMATION NEEDED TO ESTABLISH ELIGIBILITY FOR THE PROGRAM.

THE APPLICATION MUST BE COMPLETELY FILLED OUT. IF THE APPLICATION IS NOT COMPLETED, IT WILL BE RETURNED TO THE CLIENT WITH A MISSING INFORMATION LETTER THAT POINTS OUT THE INFORMATION NEEDED. THE CASE WILL BE CLOSED IF DOCUMENTATION IS NOT RETURNED WITHIN 60 WORKING DAYS FROM THE DATE ON THE MISSING INFORMATION LET-TER.

THE AT-LARGE PROGRAM WILL HAVE 14 WORKING DAYS TO PROCESS THE GRANT WHEN THE COMPLETED APPLICATION INFOR-MATION AND RECEIPTS HAVE BEEN RECEIVED BY THE AT-LARGE.
WHEN THE RECQUISITION IS FORWARDED TO THE ACCOUNTING DEPARTMENT, A MINIMUM OF 14 WORKING DAYS MUST BE ALLOWED FOR THE CHECK TO BE PROCESSED. ALL CALLS REGARDING THE APPLICATION, CHECK OR GRANT PROCESS ARE TO BE DIRECTED ONLY TO THE AT-LARGE CASE MANAGER(S).

THE AT-LARGE PROGRAM RESERVES THE RIGHT TO REVIEW PAYMENT OF GRANT IF EXPLOITATION IS SUSPECTED.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY RESPONSIBILITY IN COMPLYING WITH THE ABOVE.

APPLICANT SIGNATURE:_____   DATE:_____