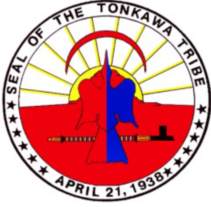


TONKAWA TRIBE OF OKLAHOMA

• DISABILITY ASSISTANCE APPLICATION •

Date: ____________________________

Disability Assistance provides a monthly stipend for eligible Tribal members who:

(A) are 18 years of age and enrolled member of the Tonkawa Tribe of Oklahoma;
(B) have needs that require personal care and supervision due to advanced age, infirmity, physical condition, or mental impairments; and
(C) are permanently incapacitated due to illness or injury and *cannot work*.

The Tonkawa Tribal Committee will determine an individual's eligibility based upon application, doctor's statement, and available resources. **Tribal members on Disability Assistance must confirm their continued need by submitting a new application by January 31st.** The application will need to be filled out in full along with the attached Doctor's statement. Their current assistance will continue until the application is reviewed and the Tribal member is notified of the decision on continued payments. The Tribal member will have a 10-day notification if the assistance is to be discontinued.

Applications must be returned by January 31st for uninterrupted benefits.

Tribal Member: ____
Address: ____
City/State/Zip: ______________________________ Phone: ________________

Proof of Assets & Income and Expenses:
SSI: ____________________
Disability: ____________________
Per Capita: ____________________
Other: ____________________

MUST VERIFY WITH CHECK STUB OR COPY OF CHECK.
Employed? Yes __________ No __________
If yes, please list employment information: __________
____
____

Certification: My signature below certifies that I understand the following:

- If I also receive disability payments from Social Security Administration, the Tribal disability payments might reduce the amount I receive from Social Security.
- I understand it is ***my responsibility*** to make sure that Tribal Payments do not decrease my Social Security payments.
- I understand that the Tonkawa Tribe is not liable if my payment from Social Security decreases because of my Tribal Disability Payment.
- I verify that I am **not currently working** and **cannot work** while receiving Tribal Disability Assistance. I understand that my benefits will be ***terminated*** if I do start working.

The Tribe is also not liable if I am forced to repay Social Security because of any overpayment due to the Tribal Disability Payments.

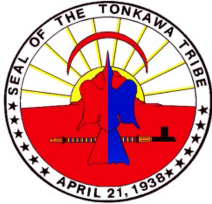
____ ____________________
Acknowledgement of Tribal Member or Guardian (POA) Date

INTERNAL USE ONLY

Date Eligibility Determined: ____________________ TTC Decision Date: ____________________

ELIGIBLE: __________ NOT ELIGIBLE: __________ APPROVED: __________ DENIED: __________

Determining Official: ____________________ TTC Signature: ____________________



TONKAWA TRIBE OF OKLAHOMA

• DISABILITY ASSISTANCE DOCTORS STATEMENT •

Date: ____________________

Doctor's Name: ____________________ Phone: ____________________

Business Address: ____________________

____

License #: ____________________ State: ____________________

Patient Name: ____________________

Last 4 of SSN: ____________________ DOB: ____________________

NOTE: Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of Guam, Puerto Rico, and the Virgin Islands) are authorized to certify the form. While Staff of the medical practice associated with the medial professional certifying the form may assist in its completion, the medical professional is responsible for the accuracy of the form's content.

Provide a basic description of the disability and/or impairment(s), e.g., "Down syndrome is a genetic disorder that causes lifelong intellectual disability (also referred to as mental retardation), developmental delays and other problems."

____

____

____

____

Are you the medical professional regularly treating this applicant for the condition(s) listed above?

☐ Yes ☐ No

Does this disability and/or impairment stop the patient from working?

☐ Yes ☐ No

Has the applicant's disability and/or impairment lasted, or do you expect it to last, 12 months or more?

☐ Yes ☐ No

MEDICAL PROFESSIONAL'S CERTIFICATION

I certify that this applicant's identity has been verified through the following United States/State /Tribal Government issued photographic identity document:

☐ Yes ☐ No

I certify under penalty of perjury under the laws of the United States of America, that the information on this form and any evidence submitted with it are all true and correct.
I am aware that the knowing placement of false information on this form and related documents may also subject me to criminal penalties.

Licensed Medial Professional Signature ____________________ Date ____________________

CONFIDENTIALITY SAFEGUARDS - In compliance with HIPAA confidentiality mandates permission for this personal health information has been obtained by the patient, and as such this letter should be treated as highly confidential records and not shared without the patient's permission.