

Klamath Tribal Health & Family Services (KTHFS) Employee Sponsored Emergency Assistance Fund Application

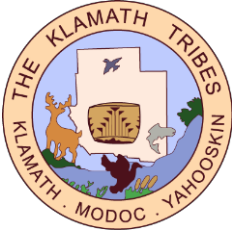
About the fund. The Employee-sponsored Emergency Assistance Fund is established by Klamath Tribal Health & Family Services (KTHFS) to assist Klamath Tribal Members who are experiencing an acute medical illness and who have exhausted all other avenues for obtaining financial assistance. Funds are made possible through KTHFS employee donations. Funds are limited and vary from month-to-month based on employee contributions. KTHFS reserves the right to administer funds according to established guidelines. All decisions are final.

How to apply.

1. Only enrolled Klamath Tribal Members (living inside or outside Klamath County) are eligible for emergency assistance. Please attach a copy of your Klamath Tribes enrollment card.
2. Applicants may be granted up to a maximum limit of **\$250.00** in a 12-month period. Applicants may submit no more than one application in a 12-month period.
3. Applications must document the emergency that has caused the financial hardship. Please review examples of approval criteria and exclusions listed on page 3.
4. Applicants are encouraged to submit any/all information they feel necessary for thorough evaluation of their request.
5. Applicants must self-report whether they have exhausted all other means of obtaining financial assistance.
6. Requests for additional information must be provided within two business days, otherwise Applicant must resubmit application.
7. Applications are confidential. However, applications are not considered protected health information (PHI) as defined by the HIPAA.

Where to submit your application.

In person	By Fax	By Mail	By E-mail
Deliver to the KTHFS Receptionist 3949 S. 6 th Street Klamath Falls, OR 97603	Attn: KTHFS Finance Fax: (541) 851-3984	Attn: Finance Dept. Klamath Tribal Health & Family Svcs. 3949 S. 6 th Street Klamath Falls, OR 97603	KTHFS-ER-Fund @klamathtribalhealth.org

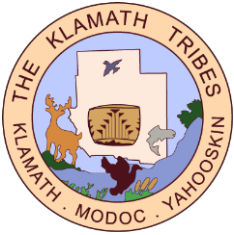


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About the Applicant	
Name	
Klamath Tribal Enrollment Number	
Address	
How do you wish to be contacted?	
Phone/message number	
Please provide the names and ages of people in your household.	

About the Emergency
Please describe your emergency including dollar amount requested. Attach additional sheets of paper if necessary.
Are you traveling away from your residence to obtain specialty medical care? If so, list appointment location, date and time.
Have you exhausted all other means of obtaining financial assistance? List other places you have contacted (e.g., Tribal Administration, etc.).

Please Read Carefully
I certify that the information that I have provided is true and correct to the best of my knowledge. I understand that this application is not intended to be a contract for payment, nor does this application obligate KTHFS to approve my application. I consent to the release of information concerning the information that I have provided on this application.
Applicant Signature: _____ Date: _____



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Approval Criteria. Examples of emergency situations typically funded	Exclusions. Examples of emergency situations typically denied
✓	X
<ul style="list-style-type: none"> ✓ Acute illness ✓ Death within the immediate family ✓ Essential utilities (e.g., water, electricity) are limited to once per person/per year, due to acute illness; applicant must provide shut-off notice ✓ Fire, flood or natural disaster ✓ Housing/rent; applicant must provide eviction notice ✓ Lost or broken eye glasses ✓ Serious accident, illness, injury, or disability ✓ Travel expenses to specialty care (e.g., hospital, lodging, transportation) 	<ul style="list-style-type: none"> • Bail • Debt • Fines (e.g., parking or speeding tickets, etc.) • Garnishments • Legal assistance • Non-essential utilities (e.g., television cable) • Other expenses deriving from non-emergency situations • Purchase of drugs, alcohol, or other chemically addictive substances including gambling, etc. • Note: Applicants requesting emergency funds for food supplies will be referred to the Klamath Tribes Commodities Program and/or local food banks.

FOR OFFICE USE ONLY

Date Application was received? _____ Does
the Applicant have a **valid** emergency? _____ Are requested funds available? _____

Amount Approved? \$ _____ Check Number: _____ Issue Date _____

Authorized by (1): _____ Authorized
by (2): _____ Application tracked
on Spreadsheet? _____ Yes _____ No

Assistance Fund Approval or Denial Comments:

