NATIVE VILLAGE OF EYAK

APPLICATION FOR BURIAL ASSISTANCE

**Name of Deceased:**

# Deceased’s Date of Birth: / / Date of Death: / /

**Tribe Enrolled To: Tribal Enrollment #:**

**Deceased’s Last Address:**

P.O. Box or Street Address City State Zip

**\*\*\*The deceased must have resided in the service area.\*\*\***

Name of Relative Applicant: Relationship to Deceased:

**Mailing Address:**

P.O. Box or Street Address City State Zip

**Home Phone#: Message Phone#: Work Phone#:**

**What are the plans you have arranged for the burial?**

**Name of Mortuary:**

**Address:**

**City: State: Zip Code:**

**Contact Person: Phone: Fax:**

**Will the casket be built?**  **Yes**  **No If yes, by whom? Please write information below.**

**Name: Address:**

**City: State: Zip: Phone:**

**Building Material Cost: $**

**Vendor Name:**

**Address:**

**City: State: Zip Code:**

**Contact Person: Phone: Fax:**

### RECORD OF INCOME AND RESOURCES

**Did the DECEASED have income from any source?** **Yes** **No**

If yes, please list source of income and amounts below.

***\*\*\*Applicant MUST provide proof of ALL income & resources\*\*\****

|  |  |
| --- | --- |
| **SOURCE OF INCOME** | AMOUNT |
| **Salary #1: Deceased’s Income/Salary** | **$** |
| **Salary #2: Spouse’s Income/Salary** | **$** |
| **Adult Public Assistance** | **$** |
| Public Assistance Burial Funds | **$** |
| **Social Security** | **$** |
| **Disability Insurance** | **$** |
| **Pension or Retirement** | **$** |
| **State Longevity** | **$** |
| **Medicare or Medicaid** | **$** |
| **Veterans Benefit** | **$** |
| **Checking Account** | **$** |
| **Savings Account** | **$** |
| **DONATION-Community** | **$** |
| **DONATION-Tribal Organization** | **$** |
| DONATION-Native Corporation | **$** |
| Other | **$** |
| Other | **$** |
| TOTAL RESOURCE INCOME | **$** |

READ BEFORE SIGNING

I apply for financial assistance for burial assistance services for the deceased who is in need. I, have received a copy of and have had explained to us, and understand the provisions of Federal Law governing fraud. I agree to supply information regarding resources and income and to notify the agency of any changes in my situation. Social Services is authorized to obtain information necessary to establish eligibility for assistance. I have read, or had explained to me, the provision of my protection under the Paperwork Reduction Act and the Privacy Act.

Relative Applicant Signature

Printed Name

Date

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| **CASE DOCUMENTATION** | | | | | | | | |
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| **Client Name:** |  | | | | | | | |
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| **DATE** |  | | | | | | | |
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