



**HOOPA VALLEY TRIBAL TANF PROGRAM**  
 PO Box 728, Hoopa, California 95546  
 530-625-4816 phone/530-625-4826 fax

**Non-Recurring Short Term Benefit Request (NRSTB)**

Date: \_\_\_\_\_

CIF# \_\_\_\_\_

Client Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Request is for (circle all that apply): Self    Spouse/Significant Other    Child(ren)  
 Other: \_\_\_\_\_

Description of the NRSTB you are requesting: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe the specific crisis/episode that created this need: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HVTTP is the payer of last resort; you must exhaust all other resources before you are eligible for NRSTB.  
 Please list circle all of the resources you have utilized: RCAA    LIHEAP    Tribe: \_\_\_\_\_  
 Other: \_\_\_\_\_ Other: \_\_\_\_\_ Other: \_\_\_\_\_

Types of NRSTB Emergency Request: (Check all that apply to your request).

Types of Service	Amount	Preferred Vendor	Type of Service	Amount	Preferred Vendor
___ Vehicle			___ Clothing		
___ Household			___ Emergency Shelter		
___ Utilities Shut Off			___ Food		
___ Utilities Shut Off			___ Other		
___ Self-Employment			___ Other		

I declare under penalty of perjury that the information I have provided on this document is true and correct to the best of my knowledge. I acknowledge that if I do not use this NRSTB as requested or if I am later found not to have been eligible to receive this NRSTB, I shall be required to repay the entire amount I received to HVTTP. I also acknowledge that by requesting this NRSTB, I may not be eligible to receive



similar benefits in the future pursuant to the HVTPP Procedure manual. The lifetime limit for supportive services is \$10,000.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
HVTPP Staff Signature Date

**To be completed by HVTPP Staff Only**

1. Has the type of service requested been duplicated within the last 12 months? Yes No
2. Budget Form Completed? Yes No
3. Supporting Documentation Received: Yes No
4. Supportive Service Request Form Completed? Yes No
5. Request: Approved Denied

If denied please elaborate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Case Worker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

7. Employment & Training Staff: \_\_\_\_\_ Date: \_\_\_\_\_

8. Family Services Manager Signature or designee: \_\_\_\_\_ Date: \_\_\_\_\_

9. Appointment Information

Appointment With: \_\_\_\_\_  
Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_



## NRSTB Budget Sheet

**Income:** *(Please report the amount of income you receive from all applicable resources).*

Cash Aid	\$	Financial Aid	\$	Disability	\$	Other	\$
Employment	\$	Unemployment	\$	Other	\$	Other	\$

**Total Income:** \$ \_\_\_\_\_

**Basic Needs Expenses:** *(Please list all applicable monthly expenses).*

Rent/Mortgage	\$	Housing	\$	Heating	\$	Insurance	\$
Electricity	\$	Water	\$	Food	\$	Auto Exp.	\$
Propane/Kerosene	\$	Gas	\$	Transportation Expenses	\$	Other	\$

**Personal Expenses:** *(Please list all applicable monthly expenses).*

Telephone	\$	Personal Hygiene	\$	Clothing	\$	Laundry	\$
Medical Expenses	\$	Child Care	\$	Other	\$	Other	\$

**Receipts: Please provide receipts for all amounts identified in Basic Needs and Personal Expenses. Receipts must reflect the dollar amount indicated in the Income section under Total Income.**

All receipts accounted for? Yes No

*If no, list receipts still needed:*

Receipt Type	Amount	Receipt Type	Amount

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Case Worker Signature: \_\_\_\_\_

Date: \_\_\_\_\_