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

Supportive Service Request

Date:________________________ CIF#_______________

Client Name:______________________________ Phone Number:__________________

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

Description of the Supportive Service you are requesting:____
____
____
____
____

Describe the specific reason crisis /episode that created this need:__________________________________
____
____

HVTTP is the payer of last resort; you must exhaust all other resources before you are eligible for Supportive Services. Please circle all of the resources you have utilized: RCAA LIHEAP
Tribe:_________________________ Other:_________________

Types of Supportive Service Request: (Check all that apply to your request).

Types of Service	Amount	Preferred Vendor	Type of Service	Amount	Preferred Vendor
_____Vehicle Repair Maint.			____Childcare		
______Job Skills, Training, Ed.			____Emergency Shelter		
______Clothing for School/ Employment			____Housing		
____Transportation			____Auto Insurance		
____Self-Employment			____Basic Medical/Dental		
____Professional License			____Special Tools/Equipment		
____Other			____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 supportive service as

requested or if I am later found not to have been eligible to receive this Supportive Service, I shall be required to repay the entire amount I received to HVTTP. I also acknowledge that by requesting this Supportive Service, I may not be eligible to receive similar benefits in the future pursuant to the HVTTP Procedure manual.

____

Client Signature Date

____

HVTTP Staff Signature Date

To be completed by HVTTP 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:_________

Supportive Service 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:_______________

Employment & Training Staff:______________________________ Date:_____________________

 CIF#_____________