Skagway Traditional Council

ERUAP (Category 2: Medical)

Applicant Full Name_____

Applicant Address _____

Applicant Phone _____

Email Address _____

ELIGIBILITY & INFORMATION

- ☐ Are you or someone in your household a fully enrolled STC member? YES / NO
  - Enrollment Number if available: _____
- ☐ Do you need help with housing cost that is due to a diagnosis and treatment that is needed outside of your living area? Please elaborate and explain as much as possible so we can better understand your situation. (Use additional Paper if needed)

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- Was someone in your household diagnosed with an illness that prevents them to work or work minimally causing an increase in housing cost burden? YES/NO
    - Amount of decrease in household income$_____
- Was someone in your household diagnosed with an illness that caused you to secure temporary housing for treatment at a place outside of your town? YES/NO
    - Was this temporary housing medically necessary for treatment as determined by the medical staff? YES/NO
    - Will you be reimbursed, or will the cost of housing be covered under any other housing plan such as Indian Health Services (IHS)? YES/NO
        - If NO, please provide the reason IHS denied the cost _____
    - Who is needed treatment outside of your residence?
        - Full Name _____
        - Relationship_____
    - How long is/was treatment_____weeks/months/years
        - Please provide a doctor's note
    - How much is the increase in housing cost _____/week/month
        - Please attach copy of lease or other agreements from landlords
    - What was the original housing cost per month prior to diagnosis?
        - Housing most monthly _____
        - Is the above mortgage or rental? MORTGAGE RENTAL
        - Please provide documentation showing monthly cost of rent (lease) or mortgage (statement).
    - Did you already complete treatment and requesting reimbursement?
        - How much did you spend in temporary living $_____
        - Please attach all housing cost receipts incurred during treatment
        - Please also attach doctor's note showing location and timeframe of treatment.

Note: Housing cost is only reimbursed for the duration of the treatment. Each complete application is taken in as First come first service and approved until the full amount of allocated budget is expended. Routine medical stays as well as any stays already coved under IHS, Medicare, or other programs will not be reimbursed.

I hereby certify that the information given to the Skagway Traditional Council is accurate and complete to the best of my knowledge and belief. I understand that false statements or information are punishable under federal law. I also understand that false statements or information are grounds for termination or denial of housing assistance.

Printed Name of Applicant: _____

Signature of Applicant: _____Date: _____