

# THLOPTHLOCCO TRIBAL TOWN

## Social Services Department

This program provides financial assistance to eligible tribal members to help with paying electric, water, gas and propane. Rent will only be paid if the utilities are included in the rent. A rental agreement or lease will need to be submitted in this situation. **The utility bill will need to be in the tribal members name or the spouse's name.** All payments will be paid to the vendor. The department staff requests that you submit your utility bills in a timely manner so that the payment that is made on your behalf will be submitted to the utility vendor by the due date. **APPLICANTS SHOULD NOT WAIT FOR THE DAY OF CUTOFF TO REQUEST SERVICES.**

**Please allow up to two (2) weeks for processing after your *completed* application has been accepted.** (Please be mindful of this when calling to check on the status of your application.)

An incomplete application could cause a delay or denial of services.

### Qualifications:

- ✓ Enrolled tribal member
- ✓ Must meet current Thlopthlocco Tribal Town Social Services income guidelines.

Some of the ***documents*** that will be requested are:

- ✓ Completed or current application on file
- ✓ Utility bill, Rental agreement or lease, invoice
- ✓ Thlopthlocco membership card for tribal members
- ✓ Social security card for **Applicant only**
- ✓ Driver's license for non-Native household member
- ✓ Income verification for **Applicant only** (if applying for Tribal Utility)
  - Two check stubs
  - Verification of SNAP benefits, if applicable (**HA screenshot**) from DHS
  - Verification of Commodities, if applicable (Eligibility award letter)
  - Verification of Unemployment benefits

Depending on what program you are applying for, will depend on what documents need to be submitted at that time.

109009 N. 3830 Rd \* Okemah, OK 74859  
Main Number: 918-560-6198 \* Toll Free: 1-866-988-8696  
FAX: 918-623-3023



THLOPTHLOCCO TRIBAL TOWN  
SOCIAL SERVICE APPLICATION

NAME: \_\_\_\_\_  
(Last) (First) (MI) (Maiden)

Address: \_\_\_\_\_ County: \_\_\_\_\_  
(Address - City - State - Zip)

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone#: \_\_\_\_\_ E-mail: \_\_\_\_\_

Household Information: Please list all persons residing in your home at this time

Please list all household members		
Household members (Not including applicant)	Date of Birth	Relationship to Applicant
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Housing situation: Own \_\_\_\_\_ Mortgage \_\_\_\_\_ Renting \_\_\_\_\_

Check below the type of assistance requested:

\_\_\_\_\_ Elderly \_\_\_\_\_ Tribal Utility \_\_\_\_\_ Medical \_\_\_\_\_ Burial \_\_\_\_\_ Emergency Assistance

**\*\* Anyone that verbally abuses, threatens bodily harm or destruction of property, curses, arrives in person under the influence or threatens a terroristic attack against employees will be denied services for 1-3 years depending on severity. See directory for more information.**

I further understand that it is my responsibility to return receipts for the Emergency Assistance to the Social Service department in order to receive future assistance. If I do not return my receipts in, I will not be able to apply for the program for a one-year period.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

THLOPTHLOCCO TRIBAL TOWN  
AUTHORIZATION to RELEASE INFORMATION

This form must be properly completed and on file before service will be considered.

I, \_\_\_\_\_, authorize these individuals to speak on my behalf.

\_\_\_\_\_

\_\_\_\_\_

Obtain information for me, or to disclose information about me as requested from time to time. I understand that this authorization is valid beginning on the date of my signature below, through December of the current year of application. I understand that I have the right to revoke this authorization at any time. I also authorize the release of any information and data needed by the Thlopthlocco Tribal Town to determine eligibility for assistance. I attest that all the information on the application is true and accurate. If found out to be otherwise, I will not be able to receive any assistance for a period of up to one year.

\*\* I have been informed that any person who knowingly, willingly and fraudulently obtains benefits and/or funds will be denied services for 3 years.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Application received date

\_\_\_\_\_  
Initial of Staff

\_\_\_\_\_  
Application approval date