



Shoshone-Bannock Tribes
CARES Act Supplemental Financial Assistance
Application Form

Application Submittal

Contact: Enrollment (208) 478-3990

Download application:
<http://www2.sbtribes.com/covid-19/>

Email Application to:
 caresactfund@sbtribes.com

Application drop off:
 Place in secured drop box at front door
 of TBC (will be emptied out daily)

Fax to: (208) 478-3894

Mail Application to:
 CARES Act Fund
 ATTN: Enrollment
 P.O. Box 306
 Fort Hall, ID 83203

FOR MINORS ONLY: each impacted Shoshone-Bannock Tribal member turning 18 year old between July 30th to December 30th need to fill out this application.

The purpose of the SBT Supplemental Financial Assistance Program is to provide a one-time payment of \$400 in economic assistance to enrolled Tribal members over the age of 18 years or older who have experienced financial hardships due to the COVID-19 pandemic. Funding of this program is in accordance with the federal CARES Act Relief Fund and is non-taxable as a Tribal general welfare assistance program.

Applicant Information

Applicant Name (print): _____

Email: _____ **Phone No.:** (____) _____ - _____

DOB: ___/___/___ **Tribal Enrollment No. (required to receive assistance):** _____

Mailing Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Do you want this to be your address on your enrollment file? Yes No

Payment will be delivered either by direct deposit or paper check per your method on file.

APPLICATION DEADLINE:
11AM on Wednesday, December 30, 2020



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Financial Need

Between March 1, 2020 and December 30, 2020, I/we have experienced/expect to experience the following (**YOU MUST CHECK AT LEAST ONE**) economic impacts caused by the COVID-19 Pandemic:

- | | |
|--|---|
| <input type="checkbox"/> Unemployment | <input type="checkbox"/> Reduced employment |
| <input type="checkbox"/> Increased utility costs | <input type="checkbox"/> Increased food costs |
| <input type="checkbox"/> Increased household cleaning costs | <input type="checkbox"/> Increased medical expenses |
| <input type="checkbox"/> Increased personal care costs for personal protective equipment and other protective measures | <input type="checkbox"/> Increased costs for telework, looking for work or children's distance learning |
| <input type="checkbox"/> Loss of self-employment/business income | <input type="checkbox"/> Transportation costs for medical testing and procedures |
| <input type="checkbox"/> Housing cost increase, foreclosure, eviction, rent | <input type="checkbox"/> Other unanticipated costs due to COVID-19 (Please list): |
| <input type="checkbox"/> Health care costs, unreimbursed prescriptions, supplements, counseling | _____ |
| <input type="checkbox"/> Increased costs for isolation or quarantine due to positive test or COVID-19 exposure | _____ |
| | _____ |

Certification (please check boxes)

- I certify that the information contained herein is true and correct to the best of my knowledge.
- I certify that these CARES Act funds I received from the Tribes shall be used for the economic impacts of COVID-19 for me that I have and are experiencing.

Applicant Signature: _____ *Date:* ___/___/___

APPLICATION WILL BE RETURNED TO APPLICANT IF NOT FILLED OUT COMPLETELY

OFFICIAL USE (Do not Fill-In)	<i>Eligible Tribal Members:</i> _____	<i>Date Received:</i> ___/___/___
<i>Reviewed by:</i> _____		<i>Date Reviewed:</i> ___/___/___