



E. Shoshone Dept. of Family Service

IIM Department

P.O Box #945 Ft. Washakie, WY 82514

Phone #307-332-6591/6592

Fax #307-332-6593

APPLICATION FOR ASSISTANCE / SERVICES

Person Requesting for Services:

Please fill out information below

Last Name:	First Name:	Middle Name:
Physical Address:		
Mailing Address:		
Phone Number:	Message Ph:	
Email Address:		
Are you the IIM account holder? <input type="checkbox"/> Yes <input type="checkbox"/> No		IIM Account #
If No, check your status to the Account holder:		<input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Need Updated Court Order		
IIM account holder Name:		
DOB:	Social Security #	Tribal Enrollment #

REQUEST FOR BENEFITS

Read the following descriptions and check all of the items for which you would like to apply.

Services	Description	Apply
Clothing Allowance	Third Party to Wal-Mart	<input type="checkbox"/>
	Third Party to Out Sportin'	<input type="checkbox"/>
	Third Party to Simply Shoes	<input type="checkbox"/>
	Other Payable to: _____	<input type="checkbox"/>
Monthly Allowance	\$150.00	<input type="checkbox"/>
	Other	<input type="checkbox"/>
Medical Expenses	Medical Expenses	<input type="checkbox"/>
	Dental Expenses	<input type="checkbox"/>
	Pharmacy Bill	<input type="checkbox"/>
	Other	<input type="checkbox"/>
Burial Expenses	Pre-Paid Funeral Plan	<input type="checkbox"/>
	Funeral Expenses	<input type="checkbox"/>
	Other	<input type="checkbox"/>
Other	For: _____	
	Payable to: _____	

What to do when you complete this form:

- Sign this form and take, mail, or fax it to E. Shoshone DFS / IIM Dept.
- After you submit this form, we will set up your interview. During your interview, we will help you complete the rest of the application and answer your questions.

What you will need to bring to your interview:

- Proof of identity, such as drivers license, school identification, tribal I.D
- Copy of the Social Security card (for IIM account holder)
- Proof of income for the parent/guardian of IIM account holder

You may be asked to give more information after your interview. You have the right to refuse to give any or all information. However, if you don't give us the information we need, your request for a distribution plan will be on hold.

Tell us about everyone who lives in the home starting with the adult head of household.

Person #1: Name of adult head of household		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Relationship to IIM Accountholder:				
Race – check all that apply <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaskan native → List Tribe you are enrolled in: _____				
Mailing address, street or P.O Box		City		State
				Zip
Physical address:				
Phone Number where you can be reached			E-mail address	

Person #2: Name		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Relationship to IIM Accountholder:				
Race – check all that apply <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaskan native → List Tribe you are enrolled in: _____				
Mailing address, street or P.O Box		City		State
				Zip
Physical address:				
Phone Number where you can be reached			E-mail address	

Person #3: Name		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Relationship to IIM Accountholder:				
Race – check all that apply <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaskan native → List Tribe you are enrolled in: _____				
Mailing address, street or P.O Box		City	State	Zip
Physical address:				
Phone Number where you can be reached		E-mail address		

Person #4: Name		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Relationship to IIM Accountholder:				
Race – check all that apply <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaskan native → List Tribe you are enrolled in: _____				
Mailing address, street or P.O Box		City	State	Zip
Physical address:				
Phone Number where you can be reached		E-mail address		

Person #5: Name		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Relationship to IIM Accountholder:				
Race – check all that apply				
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaskan native → List Tribe you are enrolled in: _____				
Mailing address, street or P.O Box		City		State
				Zip
Physical address:				
Phone Number where you can be reached			E-mail address	

Person #6: Name		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Relationship to IIM Accountholder:				
Race – check all that apply				
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaskan native → List Tribe you are enrolled in: _____				
Mailing address, street or P.O Box		City		State
				Zip
Physical address:				
Phone Number where you can be reached			E-mail address	

Biographical Information on IIM Account holder:

Personal Information:

Last Name:	First Name:	Middle Name:
Are you 18 yrs old?	If No, who is your guardian?	
Date of Birth:	Soc. Security #	Tribal Enrollment #
Physical Address:		
Mailing Address:		
Home Phone Number:	Message/Alternate Number:	

Educational Background:

High School Name:	City:	Grade / Did you graduate?
College/University Name:	City:	Academic Degree
Other educational, vocational schools, or internships		
Other credentials, licenses, or certifications		

Work Experience:

Employer:	Job Title:	Start Date / End Date:
Employer:	Job Title:	Start Date / End Date:
Employer:	Job Title:	Start Date / End Date:

Medical Background:

Name of Insurance Company	Policy #	Effective Date
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Primary care physician or clinic	Phone Number
Does IIM accountholder have any medical problems?	
If Yes, how often does the accountholder see the doctor?	

Medications: List any medications you take regularly:

Name of medicine:	Dosage/Day	Cost/Method of Payment:

List any known drug allergies: _____

List other medications, supplies, or equipment needed: _____

Mental Health:

Are you currently receiving any counseling or mental health treatment? Yes No

Do you attend support groups? Yes No

If yes, name of Provider:	Clinic Name:	Phone Number:

Have you received treatment for mental illness in the past? Yes No

If yes, name of Provider:	Clinic Name:	Phone Number:

Have you received drug or alcohol treatment in the past? Yes No

If yes, name of Provider:	Clinic Name:	Phone Number:
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Legal:

Are you currently under the E. Shoshone Dept. of Family Services: Yes No

If yes, name of Case Worker:	Are you placed in: (Circle One) Group Home, Residential Facility, Foster Care, Relative Placement, Home with parent(s)	Your case was active since:
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Are you currently under the E. Shoshone Juvenile Probation Program: Yes No

If yes, name of Case Worker:	Are you placed in: (Circle One) Group Home, Residential Facility, Foster Care, Relative Placement, Home with parent(s)	Your case was active since:
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If you are in placement out of home, when is your expected discharge date?

Have you been incarcerated? Yes No

If yes, indicate dates and charges:

Do you pay any fines or restitution payments? Yes No

If yes, Amount due: \$ _____ How Often? _____

Signature of Guardian filling out Packet

IIM Worker Signature – Received

Income Verification:

Please fill out the following columns for the total of income you received for one month, also expenses you pay for one month:

INCOME SOURCES:

Wages-self \$ _____

Wages-other \$ _____

TANF Benefits \$ _____

FoodStamps \$ _____

SSI/SSDI \$ _____

Workers Comp \$ _____

Veterans Pymt. \$ _____

PELL Grant \$ _____

Foster Care Pymt. \$ _____

Monthly Per Cap. \$ _____

Monthly Allowance from IIM. \$ _____
\$ _____

EXPENSES:

Rent/Mortgage: \$ _____

Utilities: \$ _____

Phone/Cell: \$ _____

Food: \$ _____

Clothing: \$ _____

Transportation: \$ _____

Child Care: \$ _____

Tuition/Fee's: \$ _____

Auto Pymt.: \$ _____

_____ \$ _____

TOTAL OF INCOME: \$ _____

TOTAL OF EXPENSES: \$ _____

Comment your reason for not filling out the form on your monthly income and expenses if you choose not to list your information:

Signature: _____

Distribution Plan Request:

Date: ____ / ____ /20 ____ IIM Account holder: _____

Person Requesting funds:

Account holder Parent Guardian Foster Parent Case Worker

Total amount being requested: \$ _____

Payable to: _____

Check Sent to: _____

EFT Payment **Bank Routing #** _____ **Acct #** _____

Type of Account: **Savings Account** **Checking Account**

Name on Account: _____

Attaching Copy of Bill / Invoice / Estimate

Filling out out Itemized list below

Federal Regulations require receipts for expenditures made from a supervised Individual Indian Money (IIM) account. Receipts must be provided to E. Shoshone Dept. of Family Services IIM worker before any disbursements can be made from the IIM account. The receipts must be in accordance with the distribution plan. A custodial parent or legal guardian must provide receipts for the use of the IIM funds.

By signing below you are acknowledging that you will be submitting receipts to the IIM worker for expenditures.

Signature: _____

Authorization to Release Information:

Name of IIM Account holder: _____

Parent / Guardian Name: _____

Date of Request: ____/____/20____

I hereby authorize the release of information concerning the above referenced name to:

E. Shoshone Dept. of Family Services

IIM Dept. / Attn: IIM Worker

P.O Box #945 Ft. Washakie, WY 82514

Information being requested:

I hereby state that I am giving this consent voluntarily, and I understand that the quality of the services provided is not contingent upon releasing this information.

Parent/Guardian Signature and Date

Parent / Guardian Signature and Date

ESDFS Representative Signature and Date