CONFEDERATED TRIBES OF GRAND RONDE

TRIBAL VETERAN'S DISABILITY COMPENSATION PROGRAM APPLICATION

Please Print

Name: ~~PLEASE PRINT~~ _____
First Middle Last Maiden

_____ _____ _____
Tribal Roll # Social Security Number _____ Date of birth

Address: _____
Mailing Address City State Zip

Contact Info: _____
Telephone # Cell # E-mail address

Branch of Service: _____ Discharge/Release Date: _____

CERTIFICATION AND AGREEMENT

I certify that I am an enrolled Tribal Member of the Confederated Tribes of Grand Ronde Community of Oregon (CTGR); between the ages 18 and 54, and I am currently receiving benefits from the Veteran's Disability Program through the Federal Government Veterans Administration (not to be confused with the Federal Veteran's **Pension** program).

_____ **Initial**

I agree to furnish the CTGR with all requested documentation related to consideration for program eligibility, at least but not limited to, once per calendar year. Such documentation will include, but is not limited to, proof of current VA Disability payments. **I further agree to inform the Tribe's Member Services Department of any change in my eligibility for federal VA Disability benefits.**

_____ **Initial**

I understand and agree that my failure to notify the Tribe of a change in my eligibility status or failure to provide required documentation may result in the suspension and/or revocation of my Tribal disability benefits.

_____ **Initial**

I further understand that any program repayments due, as a result of benefits received during my suspension/revocation period may be deducted from other benefits available to me from the Tribe.

_____ **Initial**

Printed Name _____ Date

Signature _____

Return to: Confederated Tribes of Grand Ronde
Attn: Member Services
9615 Grand Ronde Rd.
Grand Ronde, OR 97347
Fax: 503-879-2480

Please attach copies of your most recent correspondence from the Veterans Administration, which determines your eligibility for the above mentioned program and indicates the monthly awarded benefit and/or duration.

For Office Use Only

Date Application Received _____

Received by _____ *staff initials*

Date Supporting Documents Received _____

Program Eligibility? ☐ Yes ☐ No Benefit

Award Date _____ Reason for denial:_____

Comments:
_____

_____