CTGR-9615 Grand Ronde Rd.; Grand Ronde OR 97347 1-800-422-0232

# CTGR SUPPLEMENTAL SECURITY INCOME (SSI) OR TRIBAL DISABILITY INCOME (SSD) OR MEDICARE PART B RE-IMBURSEMENT PROGRAM PROGRAM APPLICATION

Name: _____
First Middle Last Maiden

_____ _____
Tribal Roll # Social Security Number

Address: _____
Mailing Address City State Zip

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

**Please choose one:**

## Tribal Non-Elders (18 to 54):

☐ **Tribal Supplemental Security Income**. I am requesting consideration for benefits under the Tribal Supplemental Security Income Program.

- ☐ I am an enrolled Tribal Member of the Confederated Tribes of Grand Ronde Community of Oregon,
- ☐ I am between the ages of 18 and 54,
- ☐ I receive benefits under the Federal Supplemental Security Income Program (SSI).

☐ **Tribal Disability Income Program**. I am requesting consideration for benefits under the Tribal Disability Income Program.

- ☐ I am an enrolled Tribal Member of the Confederated Tribes of Grand Ronde Community of Oregon,
- ☐ I am between the ages of 18 and 54,
- ☐ I receive benefits under the Federal ***Social Security Disability*** Insurance Program, but ***not*** the Federal ***Supplemental Security Income*** Program (SSI).

## Tribal Elders (55 or older):

☐ **Elder Tribal Supplemental Security Income**. I am requesting consideration for benefits under the Elder Tribal Supplemental Security Income Program.

- ☐ I am an enrolled Tribal Member of the Confederated Tribes of Grand Ronde Community of Oregon,

☐ I am age 55 years or older
☐ I receive benefits under the Federal Supplemental Security Income Program (SSI).

☐ **MEDICARE PART B REIMBURSEMENT**

☐ I am age 65 or greater
☐ I am applying for the Medicare Part B Reimbursement Program
☐ I receive benefits under the Federal Supplemental Security Income Program (SSI) or the Federal Social Security Disability Insurance Program and receiving Medicare Part B reimbursements

Please attach to this application:

☐ Copy Award Letter from the Social Security Administration and/or Medicare
☐ Signed Federal Information release form (enclosed). This form is required as it authorizes the Tribe to receive information from the Social Security Administration on your behalf.
☐ Copy of Medicare Card (to include both Part A and Part B coverage)

## CERTIFICATION AND AGREEMENT

I hereby certify that the information contained in and attached to the application for Tribal benefits is current, accurate and correct. I further agree to furnish the Confederated Tribes of Grand Ronde with all requested information related to my eligibility at least, but not limited to, once per calendar year as necessary to verify that I am still receiving and eligible to receive benefits from the Social Security Administration **____ (your initials).** Such documentation will include but is not limited to proof of current payments and I will inform the Tribe of any change in my eligibility for federal benefits **____ (your initials).** I understand and agree that any failure on my part to notify the Tribe or to provide necessary information **will** result in termination of benefits **_____(your initials). I understand that none of the above Tribal programs provide retroactive or recovery payments of any kind ___ (your initials). I understand and agree that if I receive more benefit than I should have (overpayment), I must pay back the amount of the overpayment. I understand that if I do not repay the Tribe for any overpayments, repayments will be deducted from benefits available to me from the Tribe. I further understand that if I have an overpayment that is not paid back, it will be considered a debt to the Tribe and subject to the Tribe's Debt Collection Ordinance**.

_____ _____
Signature Date

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# CONFEDERATED TRIBES OF GRAND RONDE
## MEMBER SERVICES
## CONSENT FOR RELEASE OF INFORMATION

Date: _____

**To: Social Security Administration**

I _____, _____ ,_____
Name date of birth, social security number

Authorize the Social Security Administration to release the below listed confidential records to:

**Confederated Tribes of Grand Ronde**
**Attn: Member Services**
**9615 Grand Ronde Rd.**
**Grand Ronde, OR 97347**
**Fax: 503-879-2480 Ph: 503-879-2223**

I am requesting this release as:

__**x**__ It is necessary to provide evidence to the Tribe of external benefits I currently receive in order for the Tribe to determine eligibility for other Tribal benefits.

_____ Other: _____
_____

Mark all that apply:

- **x** Social Security Number
- x Identifying Information (includes date and place of birth, parents' names)
- **x** Monthly Social Security benefit amount
- **x** Monthly Supplemental Security Income payment amount verification
- **x** Information about benefits/payments I received from, (dates) __all_____ to all _____
- x Information about my Medicare claim/coverage from, (dates)__all_____ to all _____
- x Record (s) from my file (specify) _____
- **x** Other (specify): _____

I am the individual to whom the information/record applies or that person's parent (if a minor or incompetent) or legal guardian. I know that if I make any representation which I know to be false in order to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

_____ _____
Signature: Date

_____
Relationship if minor or incompetent