CHEYENNE AND ARAPAHO TRIBES
HOPE
HELPING OUR PEOPLE EXCEL

CHEYENNE and ARAPAHO TRIBES

DEPARTMENT OF ADMINISTRATION

HOPE PROGRAM

P.O. BOX 167
Concho, OK 73022
Phone (405) 422-7580
Fax (405) 422-8246
hope@cheyenneandarapaho-nsn.gov

APPLICATION FOR ASSISTANCE

Applicant Name _____ **Application Date** _____
Mailing Address _____ **CDIB** _____
City, State, Zip _____ **Last 4 of Social** _____
Phone _____ **Parent/Guardian** _____

All applicants must complete an interview with a caseworker before determination of assistance can be made. All assistance requires processing time. Applications are active for 10 business days. Determination of assistance is conducted on a case-by-case basis that includes documentation and assessment information.
Documentation must be provided.

Briefly explain your crisis

_____
_____
_____
_____
_____

What type of assistance are you seeking today? (Please check all that apply)

☐ Food ☐ Utility ☐ Rent ☐ Funeral ☐ Transit ☐ Med/ICU ☐ Prescription ☐ Shelter/Temp

Check your current sources of income

☐ Employed $_____ ☐ SSI Disability $_____ ☐ Retirement $_____ ☐ Child Support $_____
☐ No Income $_____ ☐ Scholarship/Grant $_____ ☐ IIM $_____ ☐ Other Source $_____
☐ Weekly ☐ Biweekly ☐ Monthly

Are you a Veteran of the United States Military? ☐ Yes ☐ No

Current housing situation

☐ Homeless ☐ Rent ☐ Own ☐ Temp ☐ Other _____

Highest level of education

☐ High School ☐ GED ☐ Some College ☐ Bachelors/Masters ☐ Did not graduate from high school

List ALL individuals living in your household, regardless of tribal affiliation or ethnicity. Please also list yourself.

Last, First Name	Date of Birth	Age	Relationship	C&A Tribal Member?
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____
				No | Yes, 2801A_____

I certify that information I have provided is true to the best of my knowledge. I understand this information will be used to determine my eligibility for assistance with the HOPE Program and my signature allows tribal programs to share my information to determine eligibility.

_____ _____

Tribal Member Signature **Date of Application**

Code of Conduct Agreement

To ensure a cooperative, safe, and courteous environment, a Code of Conduct will be enforced by the Cheyenne and Arapaho HOPE Program. HOPE is focused on providing the client with caring and respectful service, making every attempt to avoid and physical or emotional damage to either our clients or our staff. Please adhere to the following standards.

- **Any inappropriate use of language is disrespectful and will not be tolerated**
- **Threatening/intimidating remarks about the staff to other clients are also disrespectful and will not be tolerated.**
- **Inappropriate behavior such as throwing objects, violent physical contact with others in the office, or raising a voice in anger or contempt will not be tolerated.**
- **The staff will use respectful and professional behaviors with a client and anticipate the same behavior from the client.**

HOPE understands the difficulties of going through a crisis and will make every effort to make the application process go quickly and smoothly. Please exhibit patience and understanding with the extensive application process and be informed there are consequences for any inappropriate behavior.

I, _____, have read and understand the Code of Conduct of the Cheyenne and Arapaho Tribes HOPE Program. By signing this agreement, I agree to adhere to the Code of Conduct and understand that if I breach the terms of the agreement, I will be placed on immediate suspension from the HOPE Program for up to a year from the time of offense.

_____ _____

Tribal Member Signature **Date of Application**

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ACKNOWLEDGEMENT OF TWO-TIME ASSISTANCE

THIS STATEMENT MUST BE SIGNED, DATED, AND SUBMITTED WITH YOUR APPLICATION, OR YOUR APPLICATION WILL BE VOID

This document is to acknowledge your understanding that assistance is given two times a year as needed through the HOPE Program, every six months from the time of last receiving assistance.

DO NOT WRITE IN THIS BOX. OFFICE USE ONLY.

	Date of 1st Assistance	Date of 2nd Assistance
FOOD	_____	_____
UTILITY	_____	_____
UTILITY DEPOSIT	_____	_____
RENTAL	_____	_____
RENTAL DEPOSIT	_____	_____

By signing this confirmation statement, you acknowledge that you have been made aware that You have reached your maximum assistance and are not eligible for this service until

_____

_____ _____
Client Signature **Date**

_____ _____
Caseworker Signature **Date**