COVID-19 EMERGENCY ASSISTANCE
(CRISIS RELIEF under the CARES ACT FUND)
APPLICATION

APPLICANT NAME: ________________________________

PLEASE PROVIDE ITEMS LISTED BELOW EACH BULLET POINT CATEGORY

IDENTIFICATION
- State Issued Driver License OR;
- State Issued ID

TRIBAL MEMBERSHIP
- RSIC Enrollment Card OR;
- Official letter from RSIC Enrollment Department

RESIDENCY
- Utility Bill OR;
- Lease/Housing Agreement

PROOF OF HARDSHIP AS A DIRECT RESULT OF COVID-19
- Documentation of lay-off, furlough, or other job related loss;
- Reduction in work hours due to COVID-19;
- Documentation of diagnosis of COVID-19;
- Documentation of death in immediate family due to COVID-19;
- Order/recommendation to self-isolate from a medical provider that resulted in a salary reduction;
- Placement letter for children placed in temporary, out of home placement after March 19th, 2020;
- A completed Verification of Employment Separation signed by a bona fide representative of the employer;
- Proof of non-essential business ownership in the state of Nevada and/or Reno-Sparks Indian Colony;
- Other types of documentation illustrating financial hardship caused by COVID-19;
- Denial of unemployment benefits;
- Denial of TANF benefits
- Documentation NOT accepted are hand written notes, verbal reports of job loss, self-diagnosis of COVID-19, etc.
Reno-Sparks Indian Colony Human Services
Crisis Relief under CARES ACT Application

1. Applicant Name (please print): ________________________________

2. Address: Street _____________________________  City ________ State ____  Zip _______

3. Phone Number (        ) ___________________

4. Social Security#: __________________ Date of Birth _____________

5. List names of ALL people living in Household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>DOB</th>
<th>Age</th>
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Income Information
What is your source of income? ________________________________

Employer Address: ____________________________________________

What is your gross monthly income? __________________________

Income Impact Information
- How has COVID-19 financially impacted your income? (Be specific, add a timeline if possible.)

Household Composition:
CRISIS RELIEF INFORMATION
And DISCLOSURE
CHECK RECEIPT

PLEASE READ and SIGN

Certification: By signing below, I certify that I am in receipt of a check from the Reno-Sparks Indian Colony in the amount of $____________ (Check # __________). The payment is in response to my application for financial assistance to offset losses I and my family members (if applicable) have suffered as a result of the COVID-19 Pandemic. I further certify and represent that the funds I received will be used only to purchase essential goods and services to relieve the impacts of COVID-19 and support my self-sufficiency and the self-sufficiency of my family members, if applicable. I agree to use these funds for essential needs including, but not limited to, housing, utilities, groceries, hygiene items, cleaning agents and other household necessities.

I certify that the information in my application is true and correct to the extent of my knowledge. I understand that submitting false information and/or documentation may be a crime that is punishable under Tribal and Federal Law. I also understand that false information is also a basis to disqualify me for future assistance.

Applicant Name (print) __________________________ Date ______________

Applicant Signature __________________________ Date ______________

Human Services Employee ______________________ Date ______________
COVID ASSISTANCE
SHOPPING GUIDELINES

Allowable Food Items:
- Meats
- Milk and Dairy Products
- Produce
- Bread
- Soup
- Fruit/Vegetable Juices
- Granulated Sugar or Sweeteners
- Butter
- Canned/Jarred Foods
- Pasta and Cereal
- Frozen Foods
- Baby Formula and Food

Allowable Hygiene Items:
- Shampoo and Conditioner
- Body soap/wash
- Lotion
- Toilet Paper
- Paper Towels
- Diapers and Wipes
- Feminine Hygiene Products
- Toothpaste/Brushes
- Laundry and Dish Soap
- PPE (masks, gloves, etc.)
- Disinfectant/Cleaning Agents

Unallowable Items:
- Alcohol
- Cigarettes
- Electronics
- Camping/Outdoor gear
- Toys
- Automotive items

Please Note: No other items are allowable for purchase if not listed above.
I’ve read and understand the Shopping Guidelines.

Client Signature: ___________________________  Date: __________________
**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**
*Please Complete and Sign*

**DURING THE COVID-19 PANDEMIC**

<table>
<thead>
<tr>
<th>Patient Name <em>(First, Middle, Last)</em></th>
<th>Date of Birth <em>(Month Day, Year)</em></th>
<th>Medical Record #</th>
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<th>The information is to be disclosed by:</th>
<th>And is to be provided to:</th>
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<tbody>
<tr>
<td>Name of Facility</td>
<td>Reno Sparks Tribal Health Center</td>
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<tr>
<td>Street Address</td>
<td>1715 Kuenzli Street</td>
</tr>
<tr>
<td>City/State/Zip Code</td>
<td>Reno, NV 89502</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>(775) 329-5162</td>
</tr>
<tr>
<td>Fax Number</td>
<td>(775) 334-4359</td>
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**The purpose or need for this disclosure is:** DURING THE COVID-19 PANDEMIC *(Please initial appropriate purpose)*

<table>
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<tr>
<th>Further medical care</th>
<th>Housing</th>
<th>Tribal Response</th>
<th>Other <em>(Specify)</em></th>
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**The information to be disclosed:** *(Please initial information you want disclosed)*

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<tr>
<th>Laboratory Reports <em>(Date/s)</em></th>
<th>Only records pertaining to:</th>
<th>Only the period of events from:</th>
<th>to:</th>
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<tr>
<td>__</td>
<td>COVID19</td>
<td>March 18, 2020</td>
<td>March 18, 2021</td>
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I hereby voluntarily authorize the disclosure of the above information. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that RSTHC will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating PHI for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule 45 CFR Part 164 and the Privacy Act of 1974 5 USC 552a.

**SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)* DATE**

**SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* DATE**

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretense shall be guilty of a misdemeanor (5USC 552a (i) (3)).

RCVD BY: ____________________ DATE: ____/____/_____ INITIAL__________
FAX/SCANNED/MAILED ____/____/____ INITIAL__________