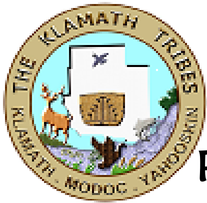

The Klamath Tribes Social Services Department
501 S Chiloquin Blvd, PO Box 436, Chiloquin OR 97624
Ph: (541) 783-2219 / Fax: (541) 783-7783

Healing Winds Program

Request for Financial Assistance Form (RFAF)

Any client requesting financial assistance must complete this "Request for Financial Assistance Form." Forms must be completed on each occasion the Applicant is requesting financial assistance. The form will only include the Client Case Number and no other identifying information. This form may be attached to procurement requests and routed through The Klamath Tribes internal authorization process.

Eligibility Requirements

1) Client must meet Eligibility Criteria of the Klamath Tribes *Healing Winds* Program.
2) Client must have a complete, signed, and current In-Take Form, Part 1.
3) Client must have a complete, signed, and current In-Take Form, Part 2.
4) Client must demonstrate request for financial assistance is directly related to their victimization.
5) Client must provide required documentation for assistance (if applicable).
6) If receiving advance funding, Client must provide copies of receipts or proof of payment within 30 days. If client has failed to provide receipts in the past, this may prohibit this type of payment assistance.
7) Assistance will be in accordance with *Healing Winds* "Assistance Determination Chart."

Victim Request for Financial Assistance

1) Today's Date: ___________________________________
2) Client Case # (Assigned by DV Program Manager): ____
3) Have you applied to other Programs or have a pending application with another Agency/Program for your request?

   YES NO

4) Do you receive public or monthly assistance from another Agency/Program for your request?

   YES NO

5) How soon do you need assistance? ________________________________
6) If the *Healing Winds* Program needs 7-10 business days to process your request, will it be in-time to assist you?

   YES NO

7) Requesting Financial Assistance with (mark all that apply):

- Auto Insurance
- Auto Maintenance Costs
- Auto Repair Costs
- Bike Purchase (non-motorized)
- Cell Phone
- Childcare Assistance
- Clothes for Interview or for Employment
- Clothing and/or Footwear (Emergency)
- Counseling for Dependents
- Fees for Divorce or Child Custody
- Fees for ID or Driver's License
- Fees to replace Birth Certificate
- Food Assistance (Emergency)
- Fuel / Gas Assistance
- Home Repairs
- Home Security System and/or Security Cameras
- Hotel or Motel Emergency Lodging
- Household Furnishings
- Housing or Rental Costs
- Legal or Attorney Fees
- Medical Costs / Co-Pay Fees
- Mortgage Costs
- Move-in / Relocation Costs
- Move-out / Relocation Costs
- Phone Service Plan
- Storage Unit / Fees
- Transportation for Dependents
- Utility Assistance (water, sewer, garbage, electricity, other heat utility, internet, and phone service)

8) Please explain what you are seeking assistance for; include Vendor and acct. # (if applicable):

9) Please explain how your request for financial assistance is directly related to your victimization:

10) Please mark all factors that apply to your request for financial assistance:

Offender and Victim have shared bank account. Offender froze account or withdrew all funds.

Offender financially supported all Victim's needs.

Offender refuses to release or return Victim's property.

Victim fled or is fleeing from Offender with little or no belongs (has to "start over").

Victim fled or is fleeing from Offender and has no safe place to go.

Victim lacks sufficient monthly income to afford unexpected or emergency costs.

Victim relied upon Offender's income for household expenditures.

Victim's property was damaged/vandalized by Offender or Offender's acquaintances.

Other (specify): ____

Acknowledgement Section

By signing below, I verify that the information I have provided is true and accurate. I promise that I will not trade or sell items that I receive through the *Healing Winds* Program. I certify any misused funds; funds gained through omission of truth; funds received fraudulently must be repaid to The Klamath Tribes *Healing Winds* Program. For funds or assistance given to client which are deemed to be fraudulent, The Klamath Tribes reserves the right to recoup funds and/or file lawsuit against client to recoup funds.

Signature: ____ Date: _____________________

Staff Use Only

Healing Winds Program must attach this form to the Program internal financial records. If requested, this form will be attached to Voucher Requisition, Purchase Order requests, or Invoices. Attach to this form, proof of payment and all required documents as specified within the *Healing Winds* "Assistance Determination Chart."

1) Client Case # (Assigned by DV Program Manager): ____

2) Date and Time Form received by Social Services Department:

   Date: ________________________ Time: ________________ AM / PM

   SS Staff who received Form (print name): ____

3) Date received by *Healing Winds* Staff: _____________________

4) Are they eligible for services?

   YES NO

   Healing Winds Staff Comments: ____

   ____

   Healing Winds Staff Signature: ____________________________________ Date: _____________________

5) Method of assistance:

   Purchase Order Reimbursement via Check *Healing Winds* Credit Card

   Voucher Marta's House

6) Request #1 – Vendor: _____________________________________ Amount: _____________________

   Acct. #: ______________________________________

   Method of assistance: ___________________________

7) Request #2 – Vendor: _____________________________________ Amount: _____________________

   Acct. #: _______________________________________

   Method of assistance: ____________________________

8) Request #3 – Vendor: ____ Amount: ______________________

Acct. #: ____

Method of assistance: ______________________________

9) Will the client receive full services through *Healing Winds*? If no, specify in question 2.

YES

NO

10) Reasons partially or not served, mark all that apply:

Conflict of interest

Did not meet statutory requirements

Hours of operation

Insufficient/lack of culturally appropriate services

Insufficient/lack of language capacity (including sign language)

Insufficient/lack of services for people with disabilities

Lack of child care

Need(s) not documented

Program reached capacity

Program rules not acceptable to victim/survivor

Program unable to provide service due to limited resources/priority-setting

Services inappropriate or inadequate for victims/survivors with mental health issues

Services inappropriate or inadequate for victims/survivors with substance abuse issues

Services not appropriate for victim/survivor

Services not available for victims/survivors accompanied by male adolescents

Transportation

Victim/Survivor Declined Services

Other (specify): ________________________________

11) Determination verified by DV Program Manager on this date: __________________ Initials: ____________

12) Assistance verified by SS Director on this date: ______________________________ Initials: ____________

13) Date *Healing Winds* staff followed-up with Applicant: ________________________ Initials: ____________