

## Wichita and Affiliated Tribes

A.R.P.A

P.O. Box 729

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## Response Household Assistance Program (RHAP)

Assistance to Households/Economic Impact Response

FY – 2024

October 1, 2023 to September 30, 2024

[ARPAdepartment@wichitatribe.com](mailto:ARPAdepartment@wichitatribe.com)

### Applicant checklist for program eligibility are as follows:

- 1. **One-Time Assistance for Household Assistance up to \$500.00**  
**Must be a Wichita and Affiliated Tribes enrolled Tribal Member (applicant) and \*\*18 years of age or older.** *18-year-old tribal members are still considered minors/students until graduated and proof must be provided for those tribal members who are seeking assistance and fall into this category.*
- 2. **Completed Application:** Your application must be filled out completely, an incomplete application could cause a delay in the process of your assistance request or jeopardize your eligibility.
- 3. **CDIB copies** – for any and **all** tribal household members  
**State ID or birth certificate** for non-tribal household members (\*\*18 years or older)
- 4. **Social Security Card copies** (for applicant and all household members \*\*18 and older)
- 5. **Income Verification** – documentation will only need to be provided when your reason for requesting assistance is income loss or a financial hardship has occurred
- 6. **Utility Assistance-** copy of recent bill, if account is NOT in applicant's name, you will need to provide proof of residency with a piece of mail post-dated within 30 days of the application.  
**Lease, W-9, and Landlord Information Form for Rental/Mortgage Assistance-** if utility or lease is not in applicant's name, please request a **NOTARIZED RESIDENCE VERIFICATION FORM**
- 7. **Hardship Experienced.** **(Reason Why You Are Requesting Assistance MUST BE FILLED OUT)**  
Need must meet one of the following qualifications resulting from a negative economic impact to the COVID-19 public health emergency:
  - Positive COVID-19 test result (must submit documentation)
  - Low or Moderate Income, Temporary Reduction in household income (must be documented)
  - Hospitalization due to COVID-19 related issues, COVID-19 Testing (work or school related)
  - Loss of earnings, Employment Search, Removal of barriers to employment
  - Elder – 55 years or over, Nursing Home Client Support, Disabled
  - Utility disconnection prevention or Eviction prevention, Restore Services, or Relocation Deposits
  - Increased Food Cost or Housing Insecurity
  - Other: *Documentation will be requested to support all requests made that do not fall under any categories within the ARPA Response Household Assistance Program*

**\*\*18 YEARS OF AGE (ADULT)-** deemed an adult tribal member only after graduated from high school or have received their General Education Diploma (GED). Proof of completion will need to be provided before assistance can be considered.

**APPLICATION IS NOT CONSIDERED COMPLETE UNTIL ALL REQUIRED DOCUMENTS ARE SUBMITTED. ONCE COMPLETED, PLEASE ALLOW (10) WORKING BUSINESS DAYS FOR PROCESSING AND ELIGIBILITY DETERMINATION**



FY-2024 ARPA

Time of Arrival to Family & Children Services office

RESPONSE HOUSEHOLD ASSISTANCE PROGRAM APPLICATION (RHAP)

DATE: \_\_\_\_\_ APPLICANT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ WICHITA TRIBAL ENROLLMENT #: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_
House # & Street Name City State Zip Code

CELL PHONE #: \_\_\_\_\_ MESSAGE PHONE #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

\*\*COPY OF ENROLLMENT/CDIB and IDENTIFICATION FOR EVERYONE MUST BE PROVIDED\*\*

LIST ALL HOUSEHOLD MEMBERS (INCLUDE APPLICANT AND SPOUSE/COMPANION)

Table with 5 columns: NAME, LAST FOUR OF SSN, RELATIONSHIP to applicant, AGE, TRIBE AFFILIATION. Row 1: 1., SELF, WICHITA.

Please use a different sheet of paper for additional household members

FAILURE TO LIST ALL HOUSEHOLD MEMBERS COULD RESULT IN A FUTURE DENIAL FROM ANOTHER HOUSEHOLD MEMBER

\*\* REASON WHY YOU ARE REQUESTING ASSISTANCE: \*\* MUST BE FILLED OUT

Have you experienced financial hardships associated with the COVID-19 pandemic that has created or increased a risk of rental or mortgage delinquency, mortgage default, loss of utilities or home energy services, or displacement?

(check all that apply)

- Positive COVID-19 Test Result, Disconnect or Eviction Notice, A reduction in household income, Elder- 55 years or older, Increase in living expenses, Loss of Employment/Temporary Layoff/or Furlough, Increased costs due to healthcare or need to care for a family member, Other financial hardship; list:

TYPE OF ASSISTANCE REQUESTING: Please Select One Option ONLY

Form with checkboxes for RENT OR MORTGAGE RELIEF, UTILITY BILL (incl. Propane), TEMPORARY HOUSING (Must meet criteria), RECONNECTION OF SERVICES, APPLIANCE REPAIR (ELDER), NATURAL DISASTER RELIEF, DEPOSIT- (UTILITY OR RENTAL), INCARCERATION ASSISTANCE, OTHER:

**VENDOR INFORMATION:**

<b>UTILITY PROVIDER/SUPPLIER</b> Utility Bill must be attached to this application	<b>LANDLORD NAME/MORTGAGE COMPANY</b> Landlord Info Form and W-9 are needed for Rental Assistance
<b>VENDOR:</b>	<b>NAME:</b>
<b>ACCOUNT #:</b>	<b>AMOUNT: \$</b>
<b>ACCOUNT HOLDERS NAME:</b>	

*Additional supporting documents are required if applicant's name does not appear on the bill.*

**ALL HOUSEHOLD INCOME:** *all earned and unearned must be reported for entire household*

NAME	SOURCE	AMOUNT	HOW OFTEN RECEIVED
		\$	
		\$	
		\$	

**I HAVE PROVIDED THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSE AND/OR MISLEADING INFORMATION WILL RESULT IN DENIAL OF APPLICATION, TERMINATION OF SERVICES, AND/OR LEGAL ACTION.** \_\_\_\_\_ (INITIALS)

**I ACKNOWLEDGE THAT IT IS MY SOLE RESPONSIBILITY AS THE CLIENT TO OBTAIN AND SUBMIT ALL REQUIRED DOCUMENTATION VERIFYING THAT MY HOUSEHOLD WAS ECONOMICALLY IMPACTED BY COVID-19 IN WHICH IS NEEDED TO COMPLETE MY APPLICATION.** \_\_\_\_\_ (INITIALS)

**I FURTHER ACKNOWLEDGE THAT THIS APPLICATION WILL BE VOIDED AFTER 14 DAYS OF NO ACTIVITY AND A NEW APPLICATION ALONG WITH ALL SUPPORTING DOCUMENTS WILL NEED TO BE RESUBMITTED.** \_\_\_\_\_ (INITIALS)

By signing this application, I authorize **The Wichita and Affiliated Tribes, Tribal Funded Social Services Department and/or the ARPA Department** to release and/or obtain any information necessary to establish eligibility for assistance and/or to include internal referral(s) within the tribal organization if deemed necessary for my household's critical circumstances.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE