The Confederated Tribes of the Grand Ronde Community of Oregon

Member Services Department
9615 Grand Ronde Road
Grand Ronde, Oregon 97347

Phone (503) 879-1358
1-800-422-0232 x 1358
Fax (503) 879-2480

CTGR Tribal Supplemental Security Income (SSI)/Disability Income (SSD)/Medicare Part "B" Reimbursement Programs Application

Name:_____
First **Middle** **Last** **Maiden**

Roll #: _____ **Social Security Number:** _____

Address:_____
Mailing **City** **State** **Zip**

Phone Number: _____ **Email:** _____

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 (SSI)** Program

□ **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 (SSD)** program but not the Federal Supplemental Security Income (SSI) program.

Tribal Elders (55 and older):

□ **Elder Tribal Supplemental Security Income (SSI) and Tribal Social Security Disability (SSD) Income.** I am requesting consideration for benefits under the Elder Tribal Supplemental Security (SSI) and/or Tribal Social Security Disability (SSD) 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 (SSI) program
- □ I receive benefits under the Federal Social Security Disability (SSD) program

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Medicare Part B Reimbursement Program:

- □ I am applying for the Medicare Part B Reimbursement Program
- □ My Medicare Part B monthly premium is deducted from my monthly Federal Supplemental Security Income (SSI) or Federal Social Security Disability (SSD) payment
- □ I am on a pre-paid plan

Please attach copies of the following to this application:

- □ Copy of Award/Benefit 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 your Medicare Card
- □ Proof of payment for Medicare Part B premium (pre-paid applicants)
- □ Copy of your Medicare Bill (pre-paid applicants)

CERTIFICATION AND AGREEMENT

Please read and initial the following:

_____ I hereby certify that the information contained in and attached to this 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.

_____ Such documentation will include but is not limited to proof of current payments, and I will inform the Tribe of any changes in my eligibility for Federal benefits.

_____ I understand and agree that any failure on my part to notify the Tribe or to provide necessary information and/or documents, will result in my termination of benefits provided by the Tribe.

_____ I understand that none of the above Tribal programs provide retroactive or recovery payments (except for the Medicare Part B Reimbursement Program).

_____ I understand and agree that if I receive an overpayment, I must pay back the amount of the overpayment or make other arrangements for reimbursement to the Tribe. I understand that if I do not repay the Tribe for any and all overpayments, the debt will be forwarded to the Tribe's Debt Collection Process under the Tribe's Debt Collection Ordinance and may interfere with future payments.

_____ _____

Signature: **Date:**

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Consent for Release of Information

Name: _____ **Roll #: _____**
First Middle Last

Date of Birth: _____ **Social Security Number: _____**

I hereby, Authorize the Social Security Administration to release the below listed confidential records to:
The Confederated Tribes of Grand Ronde
Attn: Member Services Department
9615 Grand Ronde Road
Grand Ronde, OR 97347
1-800-422-0232
Fax 503-879-2480

I am requesting this release as:

□ It is necessary to provide evidence to the Confederated Tribes of Grand Ronde of external benefits I currently receive in order for the Tribe to determine eligibility for other tribal benefits
□ Other: _____

Mark all that apply:

□ Social Security Number
□ Identifying Information (includes date and place of birth, parent's names)
□ Monthly Social Security Benefit Amount
□ Monthly Supplemental Security Income (SSI) or Social Security Disability (SSD) Payment Amount Verification
□ Information about benefits/payments I received from _____ (year) to _____ (year)
□ Information about Medicare claims/coverage from _____ (year) to _____ (year)
□ Records from my file (specific): _____
□ Other (specify): _____

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

_____ _____ _____
Printed Name: **Signature:** **Date:**

_____
Relationship if minor or incompetent

THIS RELEASE OF INFORMATION IS VALID FOR ONE YEAR FROM THE DATE SIGNED