Muscogee (Creek) Nation
Social Services Department
Social Services Office
Burial and Food for Funeral Application

APP#:__________________

SECTION 1. DECEASED INFORMATION

A. Deceased Name: ______________________ **Maiden Name:** ______________

Tribe/Roll#: ______________ **DOB:**____________ **SSN#:**____________

Physical Address: ________________________________

County: __________ **City:** ______________ **State:** ________ **Zip:** ________

B. Marital Status:

☐ Single ☐ In Relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er

If married, refer to MCN Social Security Office

Does deceased have minor children? ☐ Yes ☐ No **If yes, refer to MCN Social Security Office**

C. Was the deceased receiving any of the following? (Please check all that apply.) ☐ Yes ☐ No

☐ **Social Security Administration (SSA)** ☐ **Supplemental Security Income (SSI)**

☐ **Social Security Disability (SSDI)** ☐ **Retirement Pension**

D. Was the deceased a Veteran? ☐ Yes ☐ No

If yes, was the deceased receiving compensation or pension payment from the VA? ☐ Yes ☐ No

Was the death service-related? ☐ Yes ☐ No

Was the deceased hospitalized by VA at the time of death? ☐ Yes ☐ No

Will the deceased be buried in a national cemetery? ☐ Yes ☐ No

E. Available Resources:

Does the deceased/spouse have life insurance policy? ☐ Yes ☐ No **How much?**__________

Does the deceased have a burial policy? ☐ Yes ☐ No **How much?**__________

Does the deceased have an IIM Account? ☐ Yes ☐ No **How much?**__________ **Account #:**__________

Does the deceased have a checking or savings account? ☐ Yes ☐ No **How much?**__________

Was the deceased a crime victim? ☐ Yes ☐ No **How much?**__________

F. Was the deceased/any household members a member of a Muscogee (Creek) Nation Indian Community Center or Tribal Town?

☐ Yes ☐ No **If yes, which Community Center?** ____________________

☐ Yes ☐ No **If yes, which Tribal Town?**____________________

Revised 1/2015 ss

SECTION 2. HOUSEHOLD COMPOSITION

HOUSEHOLD MEMBER NAME	DOB	SSN#	TRIBE/ROLL#	RELATION TO HEAD OF HOUSEHOLD
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

SECTION 3. INCOME VERIFICATION
PLEASE LIST ALL INCOME FOR THE HOUSEHOLD
EARNED AND UNEARNED INCOME
(Employment, Unemployment Benefits, Child Support, TANF, SSA, SSI, SSDI, VA, Retirement, Royalties, etc.)

HOUSEHOLD MEMBER NAME	INCOME (GROSS AMOUNT)	HOW OFTEN
1.		☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI MONTHLY
2.		☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI MONTHLY
3.		☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI MONTHLY
4.		☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI MONTHLY
5.		☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI MONTHLY
6.		☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI MONTHLY

***OFFICE USE ONLY**

TOTAL GROSS MONTHLY INCOME:	
TOTAL GROSS ANNUAL INCOME:	

SECTION 4. EMPLOYMENT/EDUCATION STATUS

A. DECEASED

☐ Employed
- ☐ Full-time
- ☐ Part-time
- ☐ Medical Leave

1st Employer ____

Start Date ____

2nd Employer ____

Start Date ____

☐ Unemployed
- ☐ Laid Off
- ☐ Terminated
- ☐ Resigned
- ☐ Disabled
- ☐ Homemaker

Last Employer ________________________________

Last date worked ________________________

Highest education (please check) ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ College Degree________________________

Other:____ Other:____

B. SPOUSE/SIGNIFICANT OTHER

☐ **Employed**	☐ **Unemployed**
☐ **Full-time**	☐ **Laid Off**
☐ **Part-time**	☐ **Terminated**
☐ **Medical Leave**	☐ **Resigned**
1st Employer ______________________________	☐ **Disabled**
Start Date ______________________________	☐ **Homemaker**
2nd Employer ______________________________	**Last Employer** ______________________
Start Date ______________________________	**Last date worked** __________________

Highest education (please check) ☐ **8** ☐ **9** ☐ **10** ☐ **11** ☐ **12** ☐ **GED** ☐ **College Degree**______________________

Other:______________________________ **Other:**______________________________

SECTION 5. FUNERAL SERVICE INFORMATION

A. Date of Death: ____________________ **Place of Death:**______________________________

Funeral Home: ______________________________

Address: ______________________________

County: ______________ **City:** ______________________ **State:** __________ **Zip:** __________

Wake Service: When:______________ **Where:**______________________ **Time:**__________

Funeral Service: When:______________ **Where:**______________________ **Time:**__________

SECTION 6. RESPONSIBLE PARTY INFORMATION

(Person who signs the burial contract with the funeral home.)

A. Name: ______________________________ **Relation to deceased:** ____________________

Mailing Address: ______________________________

City:______________________________ **State:**______________ **Zip:**__________

Phone:________________ **Alternate Number:**________________ **Email:**______________________

Best way to contact (check all that apply): ☐ **Phone Call** ☐ **Text** ☐ **Mail Letter** ☐ **Email**

SECTION 7. CREEKS ONLY - AUTHORIZED PARTY INFORMATION (IF APPLICABLE)

(Person who has written permission from the responsible party to pick up the food voucher.)

A. Name: ______________________________ **Relation to deceased:** ____________________

Mailing Address: ______________________________

City:______________________________ **State:**______________ **Zip:**__________

Phone:________________ **Alternate Number:**________________ **Email:**______________________

Best way to contact (check all that apply): ☐ **Phone Call** ☐ **Text** ☐ **Mail Letter** ☐ **Email**

DISCLOSURE

FAIR HEARINGS STATEMENT:

TRIBAL BURIAL: Once the Social Services Office is in receipt of an application, it will be considered pending until all documentation required is received or up to 15 business days, whichever comes first. After 15 business days, the application will be denied. All required documentation must be received in order for eligibility to be determined. If the applicant feels the decision of the Social Services staff is in error, he/she may file a written appeal, within 10 business days from the date on the letter of denial, to the director of the Social Services Department. The Social Services director will forward the appeal letter to the Appeals Team for review and a decision will be made within 10 business days from receiving the appeal letter. All decisions will be based according to tribal and federal law, and the programs policies and procedures to ensure the integrity of the department.

PRIVACY ACT STATEMENT:

The MCN Social Services Department cannot give out applicant's information. However, Social Services can share the information with other Federal, State, Tribal offices, programs and/or businesses who have some responsibility with the services for which the applicant is applying. For any other person or program wanting information from the applicant's case file, the applicant must first give his/her consent by signing the release of information section below.

FRAUD STATEMENT:

All information pertinent to services requested is subject to verification. This includes, but is not limited to, landlords, mortgage companies, utility companies, employer, funeral homes, schools, etc. Falsification of this information shall be grounds for 1) denial of application, 2) not eligible to receive assistance for six (6) months up to a year, 3) all parties, agencies, tribes, etc. will be notified, and 4) may be forwarded to the MCN Attorney General's Office if further action is needed.

RELEASE OF INFORMATION:

Should you choose a friend or family member to receive or give information to our staff in regards to the application, please list their name, relation, and *last four digits* of their social security number for identification purposes:

Name:____________________ Relation:________________ SSN: XXX-XX-________

Name:____________________ Relation:________________ SSN: XXX-XX-________

Name:____________________ Relation:________________ SSN: XXX-XX-________

This Release of Information will remain in effect for one (1) year from date of signature or until you request to rescind authorization. **Should you choose a family member or friend to obtain information, you must check the box below authorizing it. Should you fail to check either box and/or sign, your application will be considered incomplete and <u>will be sent back to you</u>.**

I authorize the Social Services Department to obtain and/or exchange information with the person(s) listed above.

I do not wish to list any person(s).

CERTIFICATION:

By signing below, I certify I have read this application or had this application read to me and that all information provided by me, oral and written, is true and accurate. I also acknowledge I have read and understand the Fair Hearing Statement, Privacy Act Statement, Fraud Statement, and the Release of Information Section.

Responsible Party Name (printed):____________________ Date:____________

Responsible Party Signature: ____________________

OFFICE USE ONLY

Staff Member Name:____________________ **Date Completed:____________________**

Food:

Voucher Received? ☐ **Yes** ☐ **No** **Reimbursement?** ☐ **Yes** ☐ **No**

BIA Burial:

BIA Eligible? ☐ **Yes** ☐ **No** **BIA Applications attached?** ☐ **Yes** ☐ **No**