*the*
*Chickasaw Nation*
**Housing Division**
111 Rosedale Road / Post Office Box 788 / Ada, Oklahoma 74821-0788
(580) 421-8800 / Fax (580) 559-0720

***Bill Anoatubby***
***Governor***

# HANDICAP ACCESSIBILITY GRANT APPLICATION

Name of applicant: _____ Birth date: _____
First Middle Last Suffix

Physical address: _____ City: _____ State/ZIP: _____

Mailing address: _____

County: _____ Home phone: _____ Cell phone: _____

List only those improvements that will make your home more accessible to your needs.

If you are not receiving Social Security or SSI, please see the attachment for verification of your disability.

Have you previously received a handicap accessibility grant? ☐ Yes ☐ No If yes, date: _____

Are you a veteran, honorably discharged? ☐ Yes ☐ No If yes, please provide Form DD214.

Certification: I certify by my signature below that the information provided in this application is true and correct. I further acknowledge that any misrepresentation or withholding of information in applying for assistance shall be considered grounds for ineligibility. The housing division reserves the right to seek legal action and/or remedies against any applicant on the basis of fraud.

Applicant's signature: _____ Date: _____

**For Division Use Only**

Application received by: _____ Date: _____

Application reviewed by: _____ Date: _____

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## VERIFICATION OF DISABILITY

Name: _____ Date: _____
First Middle Last Suffix

Address: _____

_____

The above named individual is an applicant of the Chickasaw Nation Housing Division, and has indicated that he/she is a disabled person. If the participant has not been determined "disabled" by the Social Security Act, verification of disability must be verified by the attending physician. All information is confidential and will be used only by the Chickasaw Nation Housing Division.

_____ _____Terry Davis_____
Date Housing representative

I hereby authorize the release of this information to the Chickasaw Nation Housing Division.

_____ _____
Date Tenant/participant signature

***** The information below is to be completed by the attending physician. *****

I, _____, do hereby verify that I am the attending physician for _____. I verify that my patient meets the following definition of disability.

The term "disability" means – inability to engage in any substantial gainful activity by reason of any medical determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Comments:

**The above information is true and correct to the best of my knowledge. I understand any false information or statements are punishable under federal law.**

Physician signature: _____ Date: _____
Firm name: _____ Phone: _____
Address: _____

_____

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# REQUEST FOR RELEASE OF INFORMATION

Applicant: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

In applying for the grant, I completed an application containing various information on the purpose of the grant, with employment and income information. I certify that all of the information is true and complete. I made no misrepresentation in the application or other documents, nor did I omit any pertinent information.

I hereby give my consent for information contained in the application and in other documents required in connection with the grant, either before the grant is approved or as part of its quality control program, to be verified or re-verified. This verification or re-verification may be made by the Chickasaw Nation Housing Division, its agent, successors and/or assigns. Such information includes, but is not limited to, employment verification and copies of income tax returns and/or W-2 forms.

Photographic or carbon copies of the signatures(s) of the undersigned may be deemed to be equivalent to the original and may be used as a duplicate original.

| | | |
|---|---|---|
| Applicant signature | Date | Social Security # |
| Spouse signature | Date | Social Security # |
| Other adult member | Date | Social Security # |

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## THE CHICKASW NATION HOUSING DIVISION

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FAMILY SUMMARY SHEET
(list only members in your household)

| | First name | Middle name | Last name | Suffix | Relationship | Sex | Birth date |
|---|---|---|---|---|---|---|---|
| 1 | | | | | HEAD OF HOUSEHOLD | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |