



# The Department of Community Housing

## Public Rental Housing Program



The Department of Community Housing (DCH) has revised the **GRIC Admissions and Occupancy Policy (A&O)** to better serve the Low-income Gila River Indian Community members. With the revised A&O policy in place, this allows the DCH to accept Low Rental Housing Applications on a daily basis; applications are available for distribution.

**To qualify: (All information must be no more than 90 days old):**

Completed applications are required to have the following documents upon submission to the Department. It is the applicant's responsibility for obtaining all supporting documentation and must be available at time of submission.

The required documents include the following:

- **MUST** be 18 years of age on the date of application when submitted.
- State Identification for **all** members 18 years of age and older
- Current CDIB (Certified Degree of Indian Blood) for **all** members of the Household
- Social Security Cards for **all** members
- Birth Certificates for **all** members under 18 years of age. (Exceptions for newborns; will accept crib card/bracelet or immunization record until birth certificate is received)
- Proof of Marriage License
- Any form of Legal Identification
- Proof of Guardianship, Power of Attorney and/or other legal documents establishing custody arrangements for children placed in the applicant's home
- Signed "**Consent to Release**" form by **all** members 18 years and older
- Income Verification (**All members of Household**) – Current Check Stub(s) for Employment **Award Letter for:** SSI, SSA-Retirement, Survivors, Child Support,

**Application may be turned in at the following DCH locations:**

**DCH Main Office – Sacaton,**  
**136 South Main Street**  
**Sacaton, Arizona**  
**8 am – 5 pm (M-F)**

**DCH Westend Office – Komatke,**  
**119 Tashquinth Drive**  
**Laveen, Arizona**  
**9 am -3:30 pm (M-F)**

**Family Households are ELIGIBLE at the 80% of (HUD) Area Median Income Level (AMI):**

Income Limits Are Subject to Change

| FY - 2020 | United States Median Family Income Limits under the NAHASDA Act of 1996 |          |          |          |          |          |          |          |
|-----------|---|----------|----------|----------|----------|----------|----------|----------|
| HH Size   | 1   | 2        | 3        | 4        | 5        | 6        | 7        | 8        |
| 80%       | \$43,960  | \$50,240 | \$56,520 | \$62,800 | \$67,824 | \$72,848 | \$77,872 | \$82,896 |

**For questions or for more information please contact**  
**, Housing Intake Specialist (520) 562-3904**  
**E-mail:**



# GILA RIVER INDIAN COMMUNITY

## DEPARTMENT OF COMMUNITY HOUSING



### Low Rent Housing: Check-Off List

Name: \_\_\_\_\_

Submission Date: \_\_\_\_\_

Time: \_\_\_\_\_

|    | Recvd | Pending | Description   |
|----|-------|---------|---|
| 1  |       |         | Application   |
| 2  |       |         | Applicant/Resident Certification                            |
| 3  |       |         | Consent to Release Form (All Household Members over 18-yrs) |
| 4  |       |         | ID's for all 18 yrs. & Over                                 |
| 5  |       |         | Birth Certificate / Guardianship Letter (17yrs and under)   |
| 6  |       |         | Social Security Cards (For All House Hold Members)          |
| 7  |       |         | Current CDIB for all members of the Household               |
| 8  |       |         | Proof of Marriage License                                   |
| 9  |       |         | Proof of Guardianship, Power of Attorney                    |
| 10 |       |         | Pay-Stub (past 30-days)                                     |
| 11 |       |         | Per Cap Form or Ledger                                      |
| 12 |       |         | Verification of Income Form                                 |
| 13 |       |         | Unemployment Form (If Applicable)                           |
| 14 |       |         | DES/TSS Verification (If Applicable)                        |

Must be filled out by each adult listed on the application. (If more than one adult you will need to make copies)

Comments:

Office Use Only:

|   |                                     |
|---|-------------------------------------|
| 1 | Work Sheet (Excel)                  |
| 2 | Per Capita Verification             |
| 3 | Income Verification                 |
| 4 | DES Verification                    |
| 5 | Tribal Social Services Verification |

|   |                  |
|---|------------------|
| 6 | Denied           |
| 7 | Approved         |
| 8 | Letter to Tenant |

| Submit Date | Initial | Complete Date | Initial |
|-------------|---------|---------------|---------|
|             |         |               |         |
|             |         |               |         |
|             |         |               |         |
|             |         |               |         |
|             |         |               |         |

| Submit Date | Initial | Complete Date | Initial |
|-------------|---------|---------------|---------|
|             |         |               |         |
|             |         |               |         |
|             |         |               |         |

# GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING

## APPLICATION FOR HOUSING ASSISTANCE LOW RENT

NAME \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ BDRM SIZE: \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_

TELEPHONE: HOME: \_\_\_\_\_ CELL: \_\_\_\_\_  
WORK: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

Have you ever lived in a HUD Assistant Home under Gila River Housing Authority? ☐ Yes ☐ No

if Yes, When: \_\_\_\_\_ Where: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

### 1. Family Composition

Persons who will move into unit.

|    | Family Members | Relation | Birth Date | Age | Sex | S.S.N. | Enrollment No. |
|----|----------------|----------|------------|-----|-----|--------|----------------|
| 1  |                | H.O.H.   |            |     |     |        |                |
| 2  |                |          |            |     |     |        |                |
| 3  |                |          |            |     |     |        |                |
| 4  |                |          |            |     |     |        |                |
| 5  |                |          |            |     |     |        |                |
| 6  |                |          |            |     |     |        |                |
| 7  |                |          |            |     |     |        |                |
| 8  |                |          |            |     |     |        |                |
| 9  |                |          |            |     |     |        |                |
| 10 |                |          |            |     |     |        |                |

Anticipated Change in Family Composition: \_\_\_\_\_

### 2. Source of Family Income

| Family Member | Name of Business | Business Address | Estimated Yearly Income or Hourly Rate |
|---------------|------------------|------------------|--|
|               |                  |                  |  |
|               |                  |                  |  |
|               |                  |                  |  |
|               |                  |                  |  |
|               |                  |                  |  |

Total Yearly Family Income.....\$ \_\_\_\_\_



3. Housing Conditions:

A. Without Housing? YES NO Explain: \_\_\_\_\_

B. Directions to Present Residence: \_\_\_\_\_

4. Disabled/Handicapped/Veteran:

A. Member Disabled: \_\_\_\_\_

B. Member Handicapped: \_\_\_\_\_

C. Member In Military Service: \_\_\_\_\_



I understand that this is not a contract and does not bind either party. The above information is full, true and complete to the best of my knowledge. I have no objections to inquiries being made for the purpose of verifying the statements herein.

Name of Applicant(s): \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Interviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

| For Office Use Only  |             |                 |
|----------------------|-------------|-----------------|
| Veteran:             |             | Tribal Member:  |
| Steady Income:       |             | Overcrowded:    |
| Good Credit History: |             | Police Officer: |
| Married Couple:      |             |                 |
| Eligible:            | Ineligible: | Total Points:   |



## GRIC - DEPARTMENT OF COMMUNITY HOUSING

P.O. Box 528, 136 South Main Street  
Sacaton, Arizona 85147-0528

Phone: (520) 562-3904 Fax (520) 562-3927



### APPLICANT/RESIDENT CERTIFICATION

I/We certify that the information given to the D.O.C.H. on household composition, income, net family, assets, citizenship status, allowances and deductions or any other information submitted is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements or information are punishable under Federal Law. I/We also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy.

\_\_\_\_\_  
SIGNATURE OF HEAD OF HOUSEHOLD

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF SPOUSE

\_\_\_\_\_  
DATE

If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-Free Hot Line at 800-424-8590. (Within Washington, D.C. Metropolitan area, call 426-3500).

\*After verification by this Housing Agency, the information will be submitted to the Department of Housing and Urban Development on Form HUD-50058 (Resident Data Summary), a computer-generated facsimile of the form or on a magnetic tape.



## GRIC - DEPARTMENT OF COMMUNITY HOUSING

P.O. Box 528, 136 South Main Street  
Sacaton, Arizona 85147-0528

Phone: (520) 562-3904 Fax (520) 562-3927



**CONSENT:** I authorize and direct any Federal, State, or local agency, organization, business, or individual to release to **GRIC- DEPARTMENT OF COMMUNITY HOUSING** any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the Section 8, Rental Rehabilitation, Low-Income Public and Indian Housing, and/or other housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administering and enforcing program rules and policies.

**INFORMATION COVERED:** I understand that, depending on program policies and requirements, previous or current information regarding me or my household may be needed. Verifications and inquiries that may be requested include but are not limited to:

**Identity & Marital Status; Employment, Income, and Assets; Residences and Rental Activity; Medical or Child Care Allowances and Credit and Criminal Activity**

I understand that this authorization cannot be used to obtain any information about me that is **not** relevant to my eligibility for and continued participation in a housing assistance program.

**GROUPS OR INDIVIDUALS THAT MAY BE ASKED:** to release the above information (depending on program requirements) include, but are not limited to:

- Previous Landlords
- Past and Present Employers
- Veterans Administration
- Public Housing Agencies
- Welfare Agencies
- Retirement Systems
- Courts and Post Offices
- State Unemployment Agencies
- Banks and other Financial Institutions
- Schools and Colleges
- Social Security Administration
- Credit providers and Credit Bureaus
- Law Enforcement Agencies
- Medical and Child Care Providers
- Utility Companies
- Support and Alimony Providers

**CONDITIONS:** I agree that a photocopy of this authorization may be used for the purposes stated above. This authorization will stay in affect for a year and one month from the date signed.

### PRIVACY ACT NOTICE

**Authority:** The GRIC Department of Community Housing (DCH) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older.

**Purpose:** Your information is being collected by the GRIC Department of Community Housing (DCH) to determine your eligibility and to adequately determine the number of bedrooms needed based on your household composition and size.

**Other Uses:** To protect the Tribal Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information **will not** be otherwise disclosed or released outside of the Department of Community Housing (DCH), except as permitted or required by law.

**Penalty:** Applicants must provide **all** of the information requested by the Department of Community Housing (DCH), including all Social Security Numbers for you and all household members (ages six years and older). Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

**TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION SUPPLIED IS ACCURATE AND COMPLETE ON MY PREVIOUS RESIDENCY AND CURRENT HOUSEHOLD COMPOSITION.**

|                               |              |      |
|-------------------------------|--------------|------|
| Signature – Head of Household | Printed Name | Date |
| Signature – Co-Head           | Printed Name | Date |
| Signature – Other Adult       | Printed Name | Date |
| Signature – Other Adult       | Printed Name | Date |
| Signature – Other Adult       | Printed Name | Date |





# GILA RIVER INDIAN COMMUNITY

## Department of Community Housing HOUSING SERVICES – Verification of Assistance



Arizona Department of Economic Security  
Unemployment Insurance Program  
P. O. Box 29225 #5895  
Phoenix, AZ 85038-9225

Verification of Unemployment Income (please return completed form to address below)

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

The individual named above is an applicant/tenant for housing assistance that is subsidized through the U.S. Department of Housing and Urban Development. Federal regulations require that in order for the household to be eligible, we must verify the household's income, expenses and other information using third party written verifications. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be held in strict confidence. **We are required to complete our verification process in a short time period and would appreciate your prompt response to this request for information.**

I, the undersigned, do hereby authorize the release of the information requested to Gila River Department of Community Housing.

Applicant / Tenant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or see signed Authorization for the Release of Information)

PLEASE PROVIDE THE FOLLOWING INFORMATION:

### Unemployment Income

Unemployment Award Amount: \$ \_\_\_\_\_ Per: Week / Month (Circle one)

Beginning Date of Payments: \_\_\_\_\_ Ending Date of Payments: \_\_\_\_\_

Is client eligible for an extension of benefits? \_\_\_\_ Yes \_\_\_\_ No

Date applicant/tenant first received benefits: \_\_\_\_\_

**A print out may be attached.**

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Warning! Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

For Office use only: \_\_\_\_\_ Initial \_\_\_\_\_ Annual \_\_\_\_\_ Interim \_\_\_\_\_ Occupancy Specialist \_\_\_\_\_

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# GILA RIVER INDIAN COMMUNITY



## Department of Community Housing HOUSING SERVICES – Verification of Employment

CURRENT EMPLOYER:

NAME: \_\_\_\_\_

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

EMPLOYERS NUMBER: \_\_\_\_\_

The individual named above is an applicant for housing assistance that is subsidized through the U.S. Department of Housing and Urban Development. The person identified above has informed us that he/she has within the past 12 months been employed by your firm. Federal regulations require that in order for the household to be eligible, we must verify the household's income, expenses and other information using third party written verifications. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be held in strict confidence. **We are required to complete our verification process in a short time period and would appreciate your prompt response to this request for information.**

Consent to Release Information

Department of Community Housing

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Housing Services \_\_\_\_\_ Date \_\_\_\_\_

S.S.# \_\_\_\_\_

**-DO NOT WRITE BELOW THE LINE-**

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Date Hired: \_\_\_\_\_ Occupation / Position: \_\_\_\_\_

Current Pay Rate: \$ \_\_\_\_\_ Per: ☐ Hour / ☐ Day / ☐ Week / ☐ Month Effective Date: \_\_\_\_\_

Overtime Pay Rate: \$ \_\_\_\_\_ Per: ☐ Hour / ☐ Day / ☐ Week / ☐ Month

**ENTER THE NUMBER OF HOURS WORKED DURING THE PAST TWELVE (12) MONTHS:**

| -Average Hours:- |  | -Overtime Hours:- |  |
|------------------|--|-------------------|--|
|------------------|--|-------------------|--|

Per Day: \_\_\_\_\_ Per Week: \_\_\_\_\_ Per Day: \_\_\_\_\_ Per Week: \_\_\_\_\_

| -Year to Date:- |  |
|-----------------|--|
|-----------------|--|

Reg Pay: \_\_\_\_\_ Overtime: \_\_\_\_\_ Tips: \_\_\_\_\_ Deposit Tips: \_\_\_\_\_

**Is Employee on one of the following Leave types? Is the Employee eligible for compensation? Yes ☐ No ☐**

(Please check the ones that are applicable)

Leave of Absence: ☐ Yes ☐ No Short Term Disability: ☐ Yes ☐ No

Family Medical Leave: ☐ Yes ☐ No Long Term Disability: ☐ Yes ☐ No

Use of Annual and/or Sick Leave: ☐ Yes ☐ No Approved Donated Leave: ☐ Yes ☐ No

**If you answered yes, please complete the following:**

Last Day Worked: \_\_\_\_\_ Last Date Wage(s) received: \_\_\_\_\_

When is Employee anticipated to Return to Work: \_\_\_\_\_

Comments: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*Please return completed form via email or fax (520) 562-3927\*\***

**Warning! Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.**

For Office use only: \_\_\_\_\_ Initial \_\_\_\_\_ Annual \_\_\_\_\_ Interim \_\_\_\_\_ Occupancy Specialist \_\_\_\_\_





# GILA RIVER INDIAN COMMUNITY

## Department of Community Housing HOUSING SERVICES – Unemployment Form



I, \_\_\_\_\_ am currently unemployed at this time. I understand that if I become employed or start receiving unemployment income, I will contact Housing Services within (10) business days. I understand that failure to do so will result in removal of my application.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Housing Services

\_\_\_\_\_  
Date

### Office Hours, Monday-Friday, 8:00 a.m. – 5:00 p.m.

Main Office PO BOX 528 \* Sacaton, AZ 85247 \* (520) 562-3904 \* Fax (520) 562-3927 \*  
Maintenance Warehouse & Construction Office \* (520) 796-4550 \* Fax (520) 796-4551 \*  
West End Office \* (520) 796-4555 \* Fax (520) 796-4556 \*



# GILA RIVER INDIAN COMMUNITY

## Office of the Treasurer

Robert G. Keller, Community Treasurer



### AUTHORIZATION TO RELEASE INFORMATION

I, \_\_\_\_\_ give my authorization to the Gila River Indian Community Service Center and Housing Office, to obtain information on my behalf showing that I have or have not received the Per Capita payment that was distributed on:

1/31/\_\_\_\_

4/30/\_\_\_\_

7/31/\_\_\_\_

10/31/\_\_\_\_

### My Per Capita Office information is:

Gila River ID#: \_\_\_\_\_

Signature of Release: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Date: \_\_\_\_\_  
(To be used only if more information is required)

### District Service Center or Housing Use Only

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

### Per Capita Office Use Only

Received (stamp here): \_\_\_\_\_

Verified as follows:

☐ Did ☐ Did not receive 1/31/\_\_\_\_ pay-out

☐ Did ☐ Did not receive 4/30/\_\_\_\_ pay-out

☐ Did ☐ Did not receive 7/31/\_\_\_\_ pay-out

☐ Did ☐ Did not receive 10/31/\_\_\_\_ pay-out

PCO Verifier: \_\_\_\_\_  
(Sign & Date)



# GILA RIVER INDIAN COMMUNITY

## Department of Community Housing HOUSING SERVICES – Verification of Disability



Department of Community Housing  
P.O Box 528  
Sacaton AZ, 85147  
Fax #: 520-562-3927

**RE: Verification of Disability (please return completed form to above address)**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

The individual named above is an applicant/tenant for housing assistance that is subsidized through the U.S. Department of Housing and Urban Development. Federal regulations require that in order for the household to be eligible, we must verify the household's income, expenses and other information using third party written verifications. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be held in strict confidence. **We are required to complete our verification process in a short time period and would appreciate your prompt response to this request for information.**

I, the undersigned, do hereby authorize the release of the information requested to .

Applicant / Tenant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or see signed Authorization for the Release of Information)

### PLEASE VERIFY THE CLAIMED DISABILITY BY THE ABOVE NAMED APPLICANT/PARTICIPANT

#### For purposes of this verification, the definition of disabled is:

A person who-- (a) Has a disability as defined in section 223 of the Social Security Act (42 U.S.C. 423); or (b) Is determined to have a physical, mental or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions; or (c) Has a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(5)). The term "person with disabilities" does not exclude persons who have the disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

**Does the applicant meet the above definition of a disabled individual?**    ☐ Yes    ☐ No

Comments: \_\_\_\_\_  
\_\_\_\_\_

Evaluator/Diagnostician Name: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

**Warning! Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.**

For Office use only:    ☐ Initial    ☐ Annual    ☐ Interim    ☐ Occupancy Specialist

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**GILA RIVER INDIAN COMMUNITY**  
**Department of Community Housing**  
**136 South Main Street**  
**P O Box 528**  
**Sacaton, AZ 85147**

ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
 Family Assistance Administration  
 (Administración de Asistencia para Familias)

**AUTHORITY TO RELEASE CASE INFORMATION**  
**/AUTORIDAD PARA DIVULGAR INFORMACIÓN**  
**DEL CASO**

**REQUESTOR'S INFORMATION**

NAME (Last, First, M.I.) / NOMBRE (apellido, nombre, S.I.)

**PHONE NO. / TELEFONO**  
**(520)562-3904**

**FAX NO. / NUM. DE FAX**  
**(520)562-3927**

The person whose name and signature appear below has requested your cooperation in releasing the following information. Please complete and return this form within **3 business days** by fax or email.

*La persona cuyo nombre y firma aparecen abajo ha solicitado su cooperación para divulgar la información que sigue. Por favor llene y devuelva por fax o por correo, este formulario dentro de los 3 días.*

**AUTHORIZATION TO RELEASE INFORMATION / AUTORIZACIÓN PARA DAR INFORMACIÓN**

I hereby authorize and consent to the release of any and all information requested below concerning myself and my household's members to the requesting party above. The confidentiality of the information furnished will be preserved except where disclosure of this information is required by applicable law.

*Por la presente, autorizo y consiento en que se divulga al Department of Economic Security (Departamento de Seguridad Económica de Arizona) toda y cualquier información que se solicita a continuación acerca de mí o de los miembros de mi hogar. Se mantendrá el carácter confidencial de la información provista, excepto cuando alguna ley pertinente requiera que se haga pública.*

**PARTICIPANT'S INFORMATION**

NAME (Last, First, M.I.) / NOMBRE (apellido, nombre, S.I.)

SOC.SEC.NO or DATE OF BIRTH (DOB) / NÚM.DE SEG. O FECHA DE NACIMIENTO

**SS#:** **DOB:**

MAILING ADDRESS ( No. Street, City, State, Zip)

AZTECS NO. / NUM.DE AZTEC DATE OF REQUEST / FECHA DE SOLICITUD

SIGNATURE / FIRMA

**PARTICIPANT'S INFORMATION**

NAME (Last, First, M.I.) / NOMBRE (apellido, nombre, S.I.)

SOC.SEC.NO or DATE OF BIRTH (DOB) / NÚM.DE SEG. O FECHA DE NACIMIENTO

**SS#:** **DOB:**

MAILING ADDRESS ( No. Street, City, State, Zip)

AZTECS NO. / NUM.DE AZTECS DATE OF REQUEST / FECHA DE SOLICITUD

SIGNATURE / FIRMA

**DES OFFICE USE ONLY, DO NOT WRITE BELOW THIS LINE**  
**SOLO PARA EL USO DEL DES, NO ESCRIBE DEBAJO DE ESTA LÍNEA**

BENEFIT TYPE

Cash Assistance (CA)

☐ NA

MONTHLY AMOUNT

\$

EXPIRATION / RENEWAL DATE

BENEFIT TYPE

Nutrition Assistance (NA)

☐ NA

MONTHLY AMOUNT

\$

EXPIRATION / RENEWAL DATE

NAMES OF ALL INDIVIDUALS INCLUDED IN CASE

ADDITIONAL COMMENTS

I certify that the information provided is correct to the best of my knowledge.

NAME OF DES PERSON PROVIDING INFORMATION

SIGNATURE OF DES PERSON PROVIDING INFORMATION

DATE

TITLE

PHONE NO.





# GILA RIVER INDIAN COMMUNITY

Sacaton, Arizona 85147

Enrollment/Census Department  
Post Office Box 97  
Phone: (520) 562-9790  
Fax: (520) 562-8103

## Authorization to Release Information Form

Requestor's Name: \_\_\_\_\_ GRID# or DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I give authorization to the Enrollment/Census Department to release requested documents for:

☐ Self ☐ Minor Child ☐ GRIC Member whom I have legal guardianship of

| NAME | Date of Birth | GRID# |
|------|---------------|-------|
|      |               |       |
|      |               |       |
|      |               |       |
|      |               |       |
|      |               |       |

Please release the following:

☐ Certificate of Indian Blood ☐ BIA 4432 Form ☐ Game & Fish Wildlife Form (Eagle Feather) ☐ Family Tree (Sent by U.S. Mail)

### Delivery Method

☐ Hold for Pick-Up ☒ Mail ☐ Fax\*  
\*Original will be mailed to requestor unless otherwise indicated

Send to: (department/agency name, if applicable) Department of Community Housing

Name: \_\_\_\_\_ Phone: 520-562-3904

Address: P.O. Box 528 Fax: 520-562-3927

City, State, Zip: Sacaton Az, 85147 Deadline Date: \_\_\_\_\_  
(If Applicable)

Requestor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Notarization required if submitted by mail, fax, or a third party

State of: \_\_\_\_\_ )

County of: \_\_\_\_\_ )

Subscribed and sworn or affirmed and acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

MY COMMISSION EXPIRES:

(seal)

NOTARY PUBLIC

### Enrollment Department Use Only

Received By: \_\_\_\_\_ Date: \_\_\_\_\_

Completed By/Notes: \_\_\_\_\_ Date: \_\_\_\_\_