



GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING



Emergency Rental Assistance Program: Check-Off List

Name: _____

Submission Date: _____

	Recvd	Pending	Description
1			Application
2			Applicant/Resident Certification
3			Consent to Release Form (All Household Members over 18-ys)
4			ID's for all 18 yrs. & Over
5			Social Security Cards (For All House Hold Members)
6			Birth Certificate / Guardianship Letter
7			Pay-Stub (past 30-days)
8			Verification of Income Form
9			Per Cap Form or Check Stub
10			Unemployment Form (If Applicable)
11			DES/TSS Verification (If Applicable)
12			Letter of Hardship
13			Eviction/Delinquent Notice(s)
14			Utility Bill(s)
15			Emergency Rental Assistance Program Contract
16			Lease Agreement
17			ERAP Attestment
18			W-9 Form

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

Comments:

Office Use Only:

1	Entered on Master ERAP List (Log)
2	ERAP Calculation Work Sheet (Excel)
3	Per Capita Verification
4	Income Verification
5	DES Verification
6	Completed ERAP Contract

Submit Date	Initial	Complete Date	Initial

7	Denied
8	Approved
9	Director/Designee Approval

Submit Date	Initial	Complete Date	Initial

10	Letter to Tenant
11	Letter to Landlord

Submit Date	Initial	Complete Date	Initial

GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING

APPLICATION FOR EMERGENCY RENTAL ASSISTANCE PROGRAM

NAME _____ DATE: _____ TIME: _____

RENTAL ADDRESS: _____

TELEPHONE: HOME: _____ CELL: _____

WORK: _____ E-MAIL: _____

Have you ever lived in a HUD Assistant Home or receiving any other federal subsidy? ☐ Yes ☐ No
if Yes, When: _____ Where: _____

1. Family Composition

Persons who will move into unit.

Family Members	Relation	Birth Date	Age	Sex	S.S.N.	Race
1	H.O.H.					
2						
3						
4						
5						
6						
7						
8						
9						
10						

2. Source of Family Income: (must meet federal income at or below 80% of area median)

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

Total Yearly Family Income.....\$ _____

3. Housing Conditions:

A. Landlord Name/Address / W-9: _____

B. Amount Due: _____

4. Utility Information: (only home energy costs; no internet, vehicle, insurance, telephone or cable)

Utility Company	Type of Utility	List Months Over Due	Amount Due

5. Total Housing _____ and / or Utility Due: _____



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	
Letter of Hardship Attached:	Notice of Disconnect:
Income Attached:	Past Due Notice:
Unemployment Letter Attached:	
Eviction Notice:	Total Points:
Eligible:	Ineligible REASON:

Eligible Funding		
\$ Arrears Rent:	\$ Future Rent:	# of Mo Approved:
\$ Arrears Utility 1:	\$ Future Utility 1:	# of Mo Approved:
\$ Arrears Utility 2:	\$ Future Utility 2:	# of Mo Approved:
\$ Arrears Utility 3:	\$ Future Utility 3:	# of Mo Approved:
Sub Total Arrears:	Sub Total Future:	
Total to Include future Allocation: \$		



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 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 _____
S.S # _____

Housing Services _____ Date _____

-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

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 – 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 *

Requestor Agency

Gila River Indian Community
 Department of Community Housing
 136 S. Main Street
 PO Box 528
 Sacaton, AZ 85147

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Family Assistance Administration

(Administración de Asistencia para Familias)

**TRIBAL- AUTHORITY TO RELEASE INFORMATION
 / AUTORIDAD TRIBAL PARA DIVULGAR
 INFORMACIÓN**
REQUESTOR'S INFORMATION

Name (Last, First, M.I.) / Nombre (Apellido, Nombre, S.I.)
 Housing Services Program

Phone No. / Teléfono (520) 562-3904

FAX No. / Núm. 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 a continuación ha solicitado su cooperación para divulgar la siguiente información.
 Por favor, llene y devuelva este formulario dentro de los 3 días hábiles por fax o por correo electrónico.

**AUTHORIZATION TO RELEASE INFORMATION /
 AUTORIZACIÓN PARA DIVULGAR 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 divulgue toda y cualquier información que se solicita a continuación acerca de mí y los miembros de mi hogar. Se mantendrá la confidencialidad de la información proporcionada, excepto cuando la ley aplicable exija la divulgación de esta información.

PARTICIPANT'S INFORMATION

Name (Last, First, M.I.) / Nombre (Apellido, Nombre, S.I.)

Soc.Sec.No or Date of Birth (DOB) / Núm.de Seg. Soc. o

Fecha de nacimiento

Mailing Address (No., Street, City, State, ZIP) /

Dirección Postal (Núm. Calle, Ciudad, Estado, C.P)

AZTECS No. / Núm.de AZTECS

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. Soc. o

Fecha de nacimiento

Mailing Address (No., Street, City, State, ZIP) /

Dirección Postal (Núm. Calle, Ciudad, Estado, C.P)

AZTECS No. / Núm.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 ESCRIBA DEBAJO DE ESTA LÍNEA**
Benefit Type Cash Assistance (CA) ☐ N/A Monthly Amount \$ _____ Expiration / Renewal Date _____Benefit Type Nutrition Assistance (NA) ☐ N/A Monthly Amount \$ _____ Expiration / Renewal Date _____

Names of 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

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 _____

DOWNLOADED FILE – Revised 09-16-2020



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 _____



GILA RIVER INDIAN COMMUNITY
Department of Community Housing
Emergency Rental Assistance Program (ERAP)



This Agreement is by and between the Department of Community Housing (“DCH”), on behalf of the Gila River Indian Community (the “Community”), Post Office Box 528, Sacaton, Arizona 85147 and _____, hereinafter (“Tenant”). The DCH and the Tenant shall be collectively referred to as the “Parties”.

NOW THEREFORE AND IN CONSIDERATION of mutual covenants and agreements as set forth below, the Parties agree as follows:

1. **Purpose.** The purpose of this Agreement is to identify and define the roles and responsibilities of each of the Parties relating to the Emergency Rental Assistance Program (ERAP). The purpose of the ERAP is to provide temporary funding to eligible households that are unable to pay rent and/or utilities due to the COVID-19 pandemic.
2. **Tenant and household members.** Household members cannot be added without the approval of the DCH. The following is a complete list of the individuals living in the rental unit and are listed on the Lease Agreement:

3. **Address of rental unit.** The Tenant has entered into a rental lease to live at the following address, hereinafter the “Unit”:

4. **Lease Term and monthly lease amount.** The term of the lease between the Tenant and the Landlord/Owner begins on (mm/dd/yyyy) _____ and ends on (mm/dd/yyyy) _____. Total monthly rent amount under the Lease is \$ _____.

5. DCH ERAP Assistance Term

The term of this Agreement begins on _____ and ends on _____; however, the responsibilities of the Tenant in subsection 6 below shall not terminate and shall continue until such time as necessary to resolve any breach of this Agreement.

Type of Assistance (include Utility name)	Arrears			
	(A) # of Mo. Delinquent	(B) Mo. Payment	(C.) Fees/ charges	(D) = subtotal of A*B+C
Rent/lease:		\$ -	\$ -	\$ -
Utility 1:		\$ -	\$ -	\$ -
Utility 2:		\$ -	\$ -	\$ -
Utility 3:		\$ -	\$ -	\$ -

Type of Assistance	Projected Payments			
	(A) # of Future payments	(B) Mo. Payment	(C.) Deposits/ security	(E) = subtotal of A*B+C
Rent/lease:		\$ -	\$ -	\$ -
Utility 1:		\$ -	\$ -	\$ -
Utility 2:		\$ -	\$ -	\$ -
Utility 3:		\$ -	\$ -	\$ -

Type of Assistance	Total Fund (subtotal D & E)
Rent /lease:	\$ -
Utility 1:	\$ -
Utility 2:	\$ -
Utility 3:	\$ -

6. Responsibilities of the Tenant.

- The Tenant certifies that the landlord/owner and the Tenant have entered into a lease of the Unit. Tenant is responsible for future lease payments extending beyond this agreement term.
- The Tenant understands and agrees that ERAP assistance shall only be paid to the landlord/owner while the Tenant is residing in the Unit during the term of this Agreement.
- The Tenant understands that DCH is not responsible for the conduct of the Tenant, landlord/owner or other persons.
- The Tenant understands that any overpayment of money to the Landlord/Owner will be credited to the Tenant's following month's rental payment or refunded promptly to DCH. The Tenant

understands that overpayments will not be paid directly to the Tenant. If the Tenant receives any of the overpayment funds, the Tenant agrees to immediately refund the overpayment back to DCH. Failure to do so will result in breach of this Agreement and an obligation to pay DCH for such overpayments.

- e. The Tenant understands that the Tenant is responsible for providing true and correct information as part of the ERAP application process and not providing DCH with any false information. Failure to provide correct information for ERAP assistance will result in breach of this Agreement and an obligation to pay DCH for any ERAP assistance.
- f. The Tenant understands that the Tenant cannot receive any other source of public or private subsidy or assistance for the costs that are paid by the ERAP, and that it is the Tenant's responsibility to immediately notify DCH if any of change related to Tenant's need for ERAP assistance.
- g. The Tenant agrees to immediately notify DCH if the Tenant applies for or receives any other source of public or private subsidy or assistance for costs that are paid by the ERAP assistance because the Tenant understands that if the Tenant receives any other source of public or private subsidy or assistance for the costs paid by ERAP the Tenant will no longer be eligible for ERAP assistance from DCH and the Tenant will be responsible for paying DCH for ERAP assistance.

7. Responsibilities of DCH

- a. DCH shall provide ERAP assistance on behalf of the Tenant based on the calculation worksheet. The remaining amount will be the responsibility of the tenant. The ERAP assistance will be provided to the Landlord/Owner.
- b. DCH agrees to provide written notice to the landlord/owner on behalf of the Tenant of the ERAP Assistance.

8. Tenant's Breach of this Agreement. Breach of this Agreement will result in Tenant being responsible for paying DCH for any ERAP assistance provided on behalf of the Tenant, including any payments to the landlord/owner.

9. Assignment of this Agreement. This Agreement may not be assigned except with advance written consent of the Parties, and such assignment must be consistent with all applicable laws.

10. Indemnification. The Tenant shall indemnify, defend, protect and hold DCH, and its employees, directors, agents, representatives and assigns harmless from and against any and all actions, causes of action, demands, liabilities, losses, damages, injuries, costs, or expenses of whatever kind or nature, including reasonable attorney's fees and reasonable expenses incurred in connection with this Agreement, to the extent arising or resulting from, caused by or pertaining to Tenant's performance and/or conduct under this Agreement and/or the Tenant's lease with the landlord/owner.

11. Choice of Law. It is the intention of the parties that performance of the terms of this Agreement shall be in accordance with and pursuant to the laws of the Gila River Indian Community and that any action, special proceeding or other proceeding that may arise from, in connection with or by reason of this Agreement shall be resolved pursuant to the laws of the Gila River Indian Community and in its courts.

12. Sovereign Immunity. Unless otherwise specified herein, nothing in this Agreement, or in any related document or undertaking, shall be construed as: (i) affecting, modifying, diminishing or otherwise impairing the sovereign immunity of the Gila River Indian Community or any of its affiliates or

subdivisions, (ii) affecting the Gila River Community Courts' jurisdiction over civil and criminal matters, or (iii) authorizing or requiring the termination of any existing trust responsibility of the United States with respect to the Gila River Indian Community or to Indian people in general.

This Agreement is agreed to by the Parties as indicated by signatures below.

Gila River Indian Community

Tenant

Signature

Date

Signature (applicant)

Date

Director, Department of Community Housing

Applicant printed name

Rental Agency Remit address: _____



GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING



APPLICANT ATTESTMENT:

I attest the information provided by me is true and correct and that I am not receiving and do not anticipate receiving any other source of public or private subsidy or assistance for the costs that are subject of my application.

I understand that I cannot receive any other source of public or private subsidy or assistance for the costs that are subject of my application, that it is my responsibility to immediately notify the Gila River Indian Community Department of Community Housing (DCH) if any of my circumstances change, and I must immediately notify DCH if I apply for or receive any other source of public or private subsidy or assistance for costs that are subject of my application because I will no longer be eligible for assistance from DCH under the Emergency Rental Assistance Program.

APPLICANT SIGNATURE

DATE

APPLICANT SPOUSE / SIGNIFICANT OTHER

DATE

OTHER ADULT MEMBERS OF HOUSEHOLD

DATE

OTHER ADULT MEMBERS OF HOUSEHOLD

DATE

OTHER ADULT MEMBERS OF HOUSEHOLD

DATE

OTHER ADULT MEMBERS OF HOUSEHOLD

DATE

**Request for Taxpayer
Identification Number and Certification**

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the
requester. Do not
send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC

☐ C Corporation

☐ S Corporation

☐ Partnership

☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Print or type.
See Specific Instructions on page 3.

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

				-							
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or

Employer identification number

				-							
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Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign
Here**

Signature of
U.S. person ►

Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.



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: _____