



LUMBEE TRIBE OF NORTH CAROLINA DEPARTMENT OF ENERGY

CRISIS INTERVENTION PROGRAM (CIP) COVID-19

APPLICANT NAME

F		M		L	
Email Address:					

MAILING						PUBLIC HOUSING
PHYSICAL						

SS#	SEX	DOB	TELEPHONE NUMBER	ALTERNATE NUMBER	INCOME	INCOME TYPE	MEDICAL DEDUCTIONS	SOURCE

HOUSEHOLD MEMBERS

NAME	SS#	DOB	RELATIONSHIP	TYPE INCOME	INCOME	MEDICAL DEDUCTIONS

I AGREE TO LET THE CASE WORKER KNOW OF ANY CHANGES IN ADDRESS WITHIN 5 DAYS. IT HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THAT IT IS AGAINST THE LAW FOR ME TO MAKE FALSE STATEMENTS AS A RESULT TO RECEIVE SERVICE FOR WHICH I AM NOT ELIGIBLE. I UNDERSTAND I AM SUBJECT TO PROSECUTION IF I DO. I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THIS INFORMATION MAY BE CHECKED BY A STATE OR FEDERAL REVIEWER, AND I AGREE TO THIS REVIEW. I GIVE THE AGENCY PERMISSION TO VERIFY ANY UTILITY SUBSIDIES, INCOME, AND ASSETS TO DETERMINE MY ELIGIBILITY.

APPLICANT SIGNATURE

DATE

STAFF SIGNATURE

DATE

