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SENECA NATION DISABILITY SERVICES
DISABILITY BENEFIT APPLICATION

APPLICANT INFORMATION

Name:			Date:
			Phone:
Date of birth: / /	SSN: - -		Alt. Phone:
Physical address:			
City:		State:	ZIP Code:
Mailing address (if different):			
City:		State:	ZIP Code:
Enrolled Seneca: YES ____ NO ____		Tribal Enrollment #:	
Which Territory?		**Are you Head of Household?** ___Y ___N **Do you own property/home?** ___Y ___N	

Type of long-term benefit(s) received: **(check all that apply)**

Supplemental Security Income (SSI)____ Veterans Disability Compensation ____
Social Security Disability Insurance (SSDI)____ Railroad Disability Annuity ____
Income _________ Other______________

Are you employed: _________ **How may hours a week:** ______________

What is your disability? (Please describe or list all)

Do you have limitations? (Please list all)

PAYEE INFORMATION (IF APPLICABLE)

Name:		
Physical Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

****CHECKS WILL BE MAILED TO THE PAYEE ASSIGNED BY THE ISSUING AGENCY****

MAILING ADDRESS IF DIFFERENT THAN ABOVE:

City: State: Zip:

SIGNATURES

I certify that my answers are true and complete. I give permission for the SNI Disability Assistance Program to verify the above information for eligibility determination. I understand that any false information given will result in denial of my application and may affect my eligibility for future payments.

Applicant:	Date:
Print Name:	
Payee/Representative:	Date:
Print Name:	

FOR OFFICE USE ONLY

Rec'd: By:	App. Complete: YES NO Date Complete: Payee Docs Rec'd: YES NO N/A Needed:	Elig. Issue Date: Inelig. Reason: Entered:_____ _____ _____ Submitted:_____