APPLICATION FORM ELDER
KALISPEL INDIAN TRIBE CITIZENS

LEGAL NAME:_____ SPOUSE'S NAME:_____
First Middle Last First Middle Last

(AKA):_____ INDIAN NAME:_____
Any and all previous names used, include Maiden Name

ADDRESS:_____
Street City State Zip

MAILING ADDRESS:_____
P O Box City State Zip

SEX: ☐ Male ☐ Female

BIRTH DATE: _____ SPOUSE'S BIRTH DATE:_____

HOME TELEPHONE NUMBER:_____ E-MAIL:_____
CELL NUMBER:_____
MESSAGE NUMBER and NAME OF PERSON:_____

VOTING RIGHTS (optional): Are you registered to Vote? ☐ Yes ☐ No
Would you like more information? ☐ Yes ☐ No

ARE YOU ENROLLED IN THE KALISPEL INDIAN TRIBE? ☐ YES ☐ NO
IF YES, PLEASE IDENTIFY ENROLLMENT NUMBER:_____

DO YOU RESIDE ON THE KALISPEL INDIAN RESERVATION? ☐ YES ☐ NO

DO YOU RESIDE ON ALLOTTED LAND? ☐ YES ☐ NO
IF YES, IS IT A TRUST ALLOTMENT? ☐ YES ☐ NO

DO YOU HAVE TRANSPORTATION? ☐ YES ☐ NO

ARE YOU SEEKING LEGAL HELP FOR YOURSELF? ☐ YES ☐ NO

ARE YOU SEEKING LEGAL HELP FOR SOMEONE ELSE IN YOUR FAMILY? ☐ YES ☐ NO
IF YES, NAME THAT PERSON:_____

HAVE YOU USED OUR SERVICES BEFORE? ☐ YES ☐ NO
IF YES, WHEN:_____

HOW WERE YOU REFERRED TO US?_____

Total Monthly Income: YOURS: $ _____ SPOUSE: $ _____

Veteran Status:
☐ No
☐ Veteran
☐ Spouse of a Veteran

Disabled:
☐ Yes
☐ No

Previous Client:
☐ Yes
☐ No

Marital Status:
☐ Married
☐ Never Married
☐ Divorced
☐ Separated
☐ Widowed

Limited English-Speaking:
☐ Yes
☐ No

Means of Transportation:
☐ Own Car
☐ Family/Friend
☐ Public Transportation
☐ Senior Transportation
☐ No Transportation

LIVING ARRANGEMENT:
☐ Apartment
☐ Assisted Living Facility
☐ Condominium
☐ Homeless
☐ Jail
☐ Juvenile Detention
☐ Living in Shelter
☐ Living with Friends/Relative/Others
☐ Mental Health Facility
☐ Migrant Camp
☐ Mobile Home
☐ Nursing Home
☐ Own Home
☐ Prison
☐ Relatives
☐ Rented Home
☐ Rented Room
☐ Rents Apartment
☐ Rents House
☐ Rents Mobile home
☐ Rents Room
☐ Shelter
☐ Single Room Oc.
☐ Other:_____
☐ Unknown

NUMBER IN HOUSEHOLD: _____

NUMBER OF LIVING CHILDREN: _____

ARE YOU RECEIVING ANY OF THE FOLLOWING? (Check all that apply)

☐ Medicaid ☐ Medicare ☐ COPES ☐ Other In-Home Care Services
☐ Supplemental Social Security Income (SSI) Amount: _____
☐ Social Security Disability/Retirement Amount: _____
☐ Retirement Amount: _____
☐ Veterans' Benefits Amount: _____
☐ Temporary Assistance to Needy Families (TANF) Amount: _____
☐ Food Stamps Amount: _____
☐ Other:_____ Amount: _____
☐ Other:_____ Amount: _____
☐ Other:_____ Amount: _____
☐ Other:_____ Amount: _____

DEADLINES/COURT DATE(S)/:_____

COURT CASE NUMBER TYPE OF PROCEEDING

_____

_____

_____

_____

ADDITIONAL INFORMATION:_____

_____

_____

_____

_____

_____

_____

ADVERSE PARTY/PARTIES:

FULL LEGAL NAME:_____
First Middle Last

(AKA):_____ DATE OF BIRTH:_____
Any and all previous names used, include Maiden Name

STREET ADDRESS:_____
Street City State Zip

MAILING ADDRESS:_____
P O Box City State Zip

HOME TELEPHONE NUMBER:_____ CELL NUMBER:_____

E-MAIL ADDRESS:_____

ATTORNEY/ADDRESS/PHONE/FAX:_____

_____

_____

_____

_____

TELL US WHY YOU NEED LEGAL HELP:

DO YOU HAVE ANY DOCUMENTS RELATED TO THE DISPUTE? ☐ YES ☐ NO
(ATTACH ANY DOCUMENTS)

DATED:_____ SIGNATURE:_____