



CARES Act Relief Funds

Shareholder or Registered Descendant Application for Economic Assistance

Application must be postmarked by 11/12/2021 for consideration

(Except for any federal, state, or local investigations, auditing authority, subpoenas, or court orders, this form will be used for Koniag, Inc. internal use only and will not be disclosed to any third parties.)

Shareholder or Registered Descendant Name: _____

Maiden or Other Names Used: _____ SH or Descendant ID: _____

Street Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Best Way to Contact: Home Cell Email

(Please Circle One)

1. Are You a Tribal Citizen/Tribal Member? Yes No

Name of Tribe/s: _____

2. Do You or Your Household Members Qualify for Denali Kid Care/Medicaid? Yes No

You must certify that: (1) starting on March 1, 2020, you incurred necessary expenditures due to COVID-19; (2) any funds received through this Program will be used only for eligible expenses described below; (3); use of funds not in compliance with payment for eligible expenses must be repaid by you; and (4) any unused funds by December 31, 2021 will be returned to Koniag by January 29th, 2022.

3. I Have Incurred Necessary Expenses Due to the COVID-19 Public Health Emergency Since **March 1, 2020** and Have Been Affected by: *(Please check all that apply)*

Unemployment or Reduced Employment

Increased Food Costs

Medical Bills

Increased Utilities Cost

Increased Cost for Internet

Child/Elder Care Costs

Other: (Please Specify) _____

4. Do you currently have an eviction or foreclosure notice, or a utility shut off notice? Yes No

5. Are you concerned that your food supply will run out before you have the means to buy more? Yes No

6. Expense categories are listed below. Please rank your top three needs, with 1 being the highest and 3 being the lowest:

___ Housing Expenses

___ Quarantine Related Expenses

___ Food Expenses

___ Telework/Distance Learning Expenses

___ Medical Expenses

___ Transportation Expenses

___ Mental Health Support

___ Child/Elder Care Expenses

___ Utility Expenses

___ Sanitation Supplies

FOR STAFF ONLY

Date Received: _____

Complete: ___ YES ___ NO

Initials: _____

Eligible Expenses:

I understand and agree that any funds I receive through this Program may only be used for eligible expenses which are necessary due to the COVID-19 pandemic during the Covered Period (March 1, 2020 through December 31, 2021) and are not being reimbursed by other Federal Government programs.

The following is a general, non-exhaustive list of eligible expenses:

- Unreimbursed medical expenses related to COVID-19
- Personal care items (Personal Protective Equipment such as masks, sanitizer, hygiene products, etc.)
- Quarantine costs (cleaning supplies, medical supplies, and equipment, etc.)
- Groceries for food security during pandemic, including food shipping/delivery costs
- Transportation costs related to testing, procedures, or treatment related to COVID-19
- Payment of rent or mortgage (to avoid eviction or foreclosure, etc.)
- Home facility costs for sanitary and safe living conditions
- Utility costs such as electricity, gas, propane, water, firewood, internet, phone, etc.
- Expenses for telework or distance-learning, including internet and related equipment (computers, modems, monitors, etc.)
- Dependent care (childcare, food, supplies, etc.) due to school closures or other impacts due to COVID-19
- Other necessary expenses resulting from the ongoing COVID-19 pandemic.

Certifications:

- I am a Koniag Shareholder/registered Descendant, or the legal guardian of a Koniag Shareholder/registered Descendant.
- I certify that starting on March 1, 2020, I have incurred necessary expenditures due to the COVID-19 pandemic as indicated above, and as a result, financial assistance is necessary to ease such impacts.
- I certify that I have not received other aid from other sources to address the needs and impacts from the COVID-19 public health emergency as indicated above.
- If funds are used for anything other than eligible expenses, I will repay such funds to Koniag. If any funds are not used by December 31, 2021, I will return the unused funds to Koniag by January 29th, 2022.
- I have verified that my address and/or direct deposit information is up to date by registering to the Shareholder portal (Available at: <https://mykoniag.koniag.com>).
- I give my consent and authorization for any federal, state, or local agency to release to Koniag, Inc. any information needed to complete and verify my application for assistance.
- I understand that my application is subject to verification, and that falsification of information shall be grounds for immediate termination from the program and may subject me to federal liability and penalties.

I certify that the information I provided in this application is true and accurate.

Applicant Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____