



2021 ECONOMIC IMPACT SURVEY

NOTE: THIS SURVEY MUST BE COMPLETED BY FRIDAY, AUGUST 30, 2021 NO LATER THAN 5:00 P.M. CENTRAL STANDARD TIME TO BE ELIGIBLE FOR THE ONE-TIME 2021 ECONOMIC IMPACT STIMULUS ALLOCATION.

1. **The survey must be submitted by August 30, 2021 no later than 5:00 p.m. central standard time if being emailed to dnarp@delawarenation-nsn.gov. If mailed, the survey must be postmarked by August 30, 2021, to be eligible.**
2. **Stimulus checks will not be rushed!** Once verification of information is completed, there will be 14 business days allowed for processing and mailing out checks.
3. Each enrolled Delaware Nation Tribal citizen, 18 years old and over, will be eligible for \$2,000.00. Each enrolled Delaware Nation minor, 17 years old and younger, will be eligible for \$1,000.
4. One check will be processed in the adult's name for a total amount listed in the household. All information provided will be verified by enrollment.

ENROLLED DELAWARE NATION TRIBAL CITIZEN (18 years old or older):

Full Name of Tribal Citizen (Print): _____

Enrollment Number: _____ Contact Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

SELF-CERTIFICATION FOR 2021 ECONOMIC IMPACT (PLEASE CHECK ALL THAT APPLY):

EMPLOYMENT:

___ **Loss of Hours/Employment:** My household experienced reduced hours, furlough, lost employment, or was unable to gain employment.

___ **Worked from Home:** My employer required me to work from home which caused higher utility bills (i.e., electricity, water, internet, etc.) than normal.

___ **Returned to Work Force:** My household income was affected due to returning to the work force at a reduced hourly rate after losing employment during the pandemic.

___ **Service Industry Workers:** My household income was affected due to the lack of business during the CoVID-19 shut downs.

___ **Self-employed Workers:** My household income was affected due to the lack of business.

___ **Essential Workers:** My household had an essential worker who was at greater risk for being exposed to CoVID-19.

HEALTH:

___ A member of my household tested positive for COVID-19 and our household income was impacted with additional medical (medicine/hospital) and quarantine costs.

___ A member of my household experienced mental health issues and needed to seek treatment.

___ A member of my household passed due to COVID-19.

___ My household has needed to utilize technology for virtual medical visits.

GROCERIES, MEDICINE, AND CLEANING SUPPLIES:

___ My household has experienced higher cost for groceries, medicine and/or cleaning supplies. (This could be attributed to kids doing virtual learning; working from home; rise in costs; and or contacting COVID-19.)

ENROLLED DELAWARE NATION MINORS LIVING IN THE HOUSEHOLD FULL TIME (Please print full name):

- 1. Name: _____ Roll #: _____ Age: _____
- 2. Name: _____ Roll #: _____ Age: _____
- 3. Name: _____ Roll #: _____ Age: _____
- 4. Name: _____ Roll #: _____ Age: _____
- 5. Name: _____ Roll #: _____ Age: _____
- 6. Name: _____ Roll #: _____ Age: _____

AS THE COURT APPOINTED CUSTODIAL PARENT, I AM PRIMARILY RESPONSIBLE FOR THE DELAWARE NATION MINOR LISTED BELOW (If there is not a court ordered custodial parent, funds will be distributed to the enrolled Delaware Nation parent.):

- 1. Name: _____ Roll #: _____ Age: _____
- 2. Name: _____ Roll #: _____ Age: _____
- 3. Name: _____ Roll #: _____ Age: _____
- 4. Name: _____ Roll #: _____ Age: _____

PLEASE CERTIFY:

By signing or electronically signing below, I certify that the above information is true and correct to the best of my knowledge.

Signature

Date

COMMENTS OR MESSAGE:

NOTICE: This form will only be mailed to Tribal citizens 18 and over who do not have a current email or phone number on file. If a family member needs a mailed copy, please call (405) 247-2448 ext. 1112.