# KAWERAK, INC.

## TRIBAL WELFARE ASSISTANCE DEPARTMENT

Phone 1.800.478.5230 or 443.4370

## GENERAL ASSISTANCE PROGRAM INFORMATION

Kawerak General Assistance Program is an income based, last resort assistance program for tribal members in a federally recognized tribe who reside in the Kawerak Tribal Welfare Assistance compact service areas listed below. The General Assistance Program is meant to help tribal residents with "unmet needs" costs when no other resources are available (such as Public Assistance). Applicants must show there is a need for assistance for essential current unmet needs such as FOOD, CLOTHING, SHELTER, and UTILITIES. Our priority is to assist eligible households to increase self-sufficiency. If there are no jobs available, you may be required to seek, attend and complete training. If you have children in your household under 18 yrs old, you will be required to apply for State of Alaska Temporary Assistance Program (ATAP).

## KAWERAK TRIBAL WELFARE COMPACT SERVICE AREAS (must have been residing)

**Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Savoonga, Shaktoolik, Shishmaref, Solomon Stebbins, Saint Michael, Teller, Wales, White Mountain.**

***INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED***

## ELIGIBILITY GUIDELINES

- ☐ Applicants must be Tribally Enrolled in an Alaska Native or American Indian in a federally recognized tribe;
- ☐ Applicant must provide proof of residency within the Kawerak compact service areas listed above; and
- ☐ Applicant must meet the low income requirements and be able to show an unmet need.

## MAY BE INELIGIBILE

If applicant(s) quit their job or are already receiving or have been suspended from the programs listed below, they may not be eligible for assistance through General Assistance:

- ☐ If you quit a job or refused a job offer within the last 90 days for reasons within your control,
- ☐ If you are already receiving similar assistance such as ATAP, APA, SSI Disability,
- ☐ If your ATAP case has closed due to a program violation,
- ☐ If you do not live in one of Kawerak compact service areas listed above, and/or
- ☐ If you are a Unalakleet tribal member, contact your IRA office for assistance.

## *IMPORTANT POINTS TO REMEMBER*

- ☐ Any General Assistance applications received after the 10th are considered late applications with exception to mailed applications post marked before the 10th of the month.
- ☐ It can take up to 14 days to take action on any application and no longer than 30 days to determine eligibility.
- ☐ If you have any children under 18 yrs old, you are required to apply for State ATAP at the same time.
- ☐ You must follow steps your Individual Self-Sufficiency Plan steps or your Case Plan.
- ☐ If you don't have your high school diploma or GED, you may be required to work on obtaining your GED.
- ☐ If there is no work available, you must consider & apply for and attend training.
- ☐ You must provide copies of current bills; we cannot assist with cut off notices past due bills, loans, or credit cards.
- ☐ All vouchers are sent by mail ONLY, to avoid duplication of vouchers.

## *IMPORTANT AGENCY TELEPHONE NUMBERS*

| AGENCY | PHONE | FAX |
|---|---|---|
| Public Assistance ATAP, Food Stamps, Medicaid, GRA. APA | 443.2237/1.800.478.2236 | 1.888.574.2307 |
| Nome Job Center – Dept of Labor & Workforce | 443.2626/1.800.478.2626 | 443.2810 /1.800.478.2810 |
| Unemployment office (10am-3pm) | 1.888.252.2557 | 907.465.5573 JNU |
| Social Security Administration | 1.800.478.0391 | 907.456.0333 |
| State Heating Assistance Program | 1.800.470.3058 | 907.465.3319 |
| Nome Eskimo Community (NEC tribal members in Nome) | 907.443.2246 | 907.443.3539 |
| Kawerak ABE/GED/ESL Program | 1.800.478.7574 | 907.443.4471 |
| Kawerak Vocational Rehabilitation | 1.877.759.34362 | 907.443.4475 |
| Kawerak Vocational Training | 1.888.898.5171 | 907.443.4479 |
| Cook Inlet Tribal Council- Anchorage Residents | 793.3600/1.877.985.5900 | |
| RuralCap Weatherization Program for Western Alaska | 1.800.478.7227 | |
| | | |

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P.O. Box 948 ~ Nome, AK 99762
Web site: www.kawerak.org
Ph: (907) 443.4370 ~1.800.478.5230
Fax: (907) 443.4485 ~ 1.800.450.4341

## APPLICATION PROCESS

1. Complete the application and attach all items from the checklist below, then fax the completed application to 1.855.445.4477 or 443.4486 before the 10th of the month. After the application is faxed, call 1.800.478.5230 to make sure the fax came through. Incomplete applications will not be processed. Each Adult in the case must complete a separate Individual Self-Sufficiency Plans (ISP) and separate work searches. Households with children under 18 years old are required to apply for Public Assistance ATAP at the same time as Kawerak TWA. All applicants must apply for or be receiving Food Stamps with the State of Alaska and have applied for all other resources.
2. The Tribal Welfare Assistance office will contact your current/former employer, Public Assistance, Unemployment office, Nome Job Center, IRA, Bingo/Pull Tabs, City office & other agencies to verify information you report in your application. We may also call others in your community, if information reported is questionable.
3. An eligibility decision will be made on the completed, signed application within 30 days of the application date.
4. A determination letter is sent through the mail and if eligible, your vouchers are mailed to the vendors. Faxed vouchers are not permitted to avoid a possible duplication of vouchers.

## *GENERAL ASSISTANCE APPLICATION CHECKLIST*

Please make sure all items listed below are attached or your application will be considered incomplete.

- ☐ Complete the General Assistance application. Make sure all areas are complete and signed.
- ☐ Provide proof of Tribal Enrollment or Certificate of Indian Blood: also submit a Certificate of Indian Blood or proof of tribal enrollment for all persons & children in your household. If this program has one already on file, it is not needed.
- ☐ Bank or Credit Union Statement: Adult applicants submit all bank statements for the past 30-60 days for savings and/or checking accounts.
- ☐ Provide copies of current bills; we cannot assist with cut off notices, past due bills, late fees, accounts, loans or credit cards.
- ☐ Verification of residency, rent receipt or copies of bills with your name: Attach rental agreement or complete the landlord shelter statement from the Tribal Welfare Assistance office. Report **all** people living in your household on your application.
- ☐ Proof of all sources of income, copies of check stubs and correspondence from agencies such as ATAP, Food Stamps, Child Support, SSI, SSA, Unemployment Benefits, Senior Benefits, Veterans Benefits, etc.
- ☐ Report all self employment income for the prior & current month and the cost of making the crafts.
- ☐ Apply for Unemployment Benefits by calling 1.888.252.2557. Provide proof of application/denial. Keep **all** correspondence and fax to the our office at: 1.877.824.4455 or 443.4455
- ☐ Submit an updated resume with your application (at the initial application and every 3 months after when receiving General Assistance). Register with ALEXsys Job Search program and have a current resume online with the Nome Job Center (NJC). Go to www.jobs.state.ak.us Please call the Nome Job Center (NJC) at 1.800.478.2626 or 443.2626 or go to the Nome Job Center. You must call NJC to update your resume if newly employed and update every 3 months.
- ☐ Work Search is required if you are able to work. You must accept employment if it's offered to you or be disqualified for 60-90 days. If you decide to attend a training program you must show proof that you were accepted, the dates you will attend and scholarships you will receive. This will be added to your Individual Self-Sufficiency Plan.
- ☐ If you are unable to work, contact the Welfare Specialist at 1.800.478.5230 or 443.4370. There are certain forms that need to be completed and an exemption Case Plan needs to be created. You must provide a health provider/doctor/therapist statement that may exempt you from the work requirement, and you must work on your medical case plan.

# KAWERAK, INC.

## TRIBAL WELFARE ASSISTANCE DEPARTMENT

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## GENERAL ASSISTANCE APPLICANT'S INFORMATION

| Your Last Name | Your First Name and Middle Initial | Social Security Number |
|---|---|---|
| | | |

| Mailing Address/PO Box | ☐ Own home<br>☐ Rent house or apt | ☐ Rent room<br>☐ live with someone | Your Age | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Home Address/Physical Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Cell/Home Phone # | Message Phone # | E-mail Address: | Other Names you have used: |
|---|---|---|---|
| | | | |

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with partner, girl/boy friend

| Veteran:<br>☐ No ☐ Yes | Date of Discharge: | Registered with Selective Service?<br>☐ No ☐ Yes |
|---|---|---|
| | | |

| | |
|---|---|
| Are you willing to take a drug test?<br>☐ No ☐ Yes | If no, why? |
| Are you working right now?<br>☐ No ☐ Yes | If yes, where and what is the phone number? |
| Have you worked in the last 90 days?<br>☐ No ☐ Yes | If yes, where and what is the phone number? |
| Are you able to work?<br>☐ No ☐ Yes | If no, explain why: |
| Are you receiving any other help, such as Public Assistance or Tribal Assistance?<br>☐ No ☐ Yes | If yes, what type of assistance?<br>☐ Food Stamps ☐ ATAP ☐ APA ☐ GRA ☐ Medicaid ☐ SSI ☐ Native TANF<br>☐ Kawerak Direct Employment ☐ Supportive Services ☐ Vocational Rehab |

## APPLICANT HOUSEHOLD INFORMATION

**LIST ALL PEOPLE LIVING IN YOUR HOUSEHOLD:** (you, spouse, boyfriend, girlfriend, partner, roommates, children, parents, grandparents, aunts, uncles, others, etc.). Include everyone. Use a separate sheet of paper if needed for others.

| Full Legal Name | Relationship | DOB/Age | SSN | Highest Grade Completed | Village or Tribe enrolled | (ofc use) * |
|---|---|---|---|---|---|---|
| | **SELF** | / | | | | |
| | | / | | | | |
| | | / | | | | |
| | | | | | | |
| | | / | | | | |
| | | / | | | | |

## EMPLOYMENT/TRAINING HISTORY

LIST YOUR (AND YOUR PARTNERS') MOST RECENT WORK EXPERIENCE:

| WHO / TYPE OF WORK | NAME OF PLACE WORKED | START DATE AND END DATE |
|---|---|---|
| Self / | | From: / / To: / / |
| / | | From: / / To: / / |

LIST YOUR (AND YOUR PARTNERS') TRAINING EXPERIENCE:

| WHO / TYPE OF TRAINING | TRAINING FACILITY | START DATE AND END DATE |
|---|---|---|
| Self / | | From: / / To: / / |
| / | | From: / / To: / / |

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## YOUR MONTHLY SHELTER COSTS (provide copies of bills in your name)

| | | | | | |
|---|---|---|---|---|---|
| Rent | $ | Electricity | $ | Water/Sewer | $ |
| Room/Space Rent | $ | Heating | $ | Utilities | $ |
| Mortgage payment | $ | Telephone | $ | Other | $ |

## FAMILY INCOME AND AVAILABLE FUNDS

**List all income** that you and family have received during the last 30 days and current available funds. Attach check stubs.
**ALL ADULTS in the household must provide income information *for the last month, with verification of income.***

| Source of Income—attach check stubs | Applicant #1 | Other adults | **Month/Yr & who received check** |
|---|---|---|---|
| Wages, net salary (attach paystubs) | $ | $ | *Work #:* |
| Unemployment Insurance Benefits (UIB) | $ | $ | |
| PUBLIC ASSISTANCE - ATAP, TANF, ASAP, GRA | $ | $ | |
| FOOD STAMPS | $ | $ | |
| Senior Benefits Program (State longevity) | $ | $ | |
| Veteran's Benefits | $ | $ | |
| Federal Tax Refund (IRS) | $ | $ | |
| Board Member Stipend | $ | $ | *Name of Board:* |
| Self Employment, Carving, beading, baking, etc. | $ | $ | *Cost of supplies:* |
| Child support and alimony (receiving) | $ | $ | |
| Foster care payments | $ | $ | |
| Social Security (SSA) **retirement, survivors benefits** | $ | $ | |
| Supplemental Security Income (SSDI) **Disability** | $ | $ | |
| Cash-out of retirement or pension plan | $ | $ | When: |
| Native Corporation dividends | $ | $ | *Native Corp Name:* |
| Checking account (current balance) | $ | $ | |
| Savings account (current balance) | $ | $ | |
| Bingo or pull tab winnings this month | $ | $ | |
| Kawerak Supportive Services/Direct Employment | $ | $ | |
| Kawerak Vocational Rehabilitation | $ | $ | |
| Other income (specify) | $ | $ | |
| **Total Income for Last 30 Days** | **$** | **$** | |
| Alaska Permanent Fund Dividend (PFD) | $ | $ | *PFD Garnished:* ☐*Yes* ☐*No* |

**READ BEFORE SIGNING -** I hereby certify that all information made on or in connection with this application is true and complete to the best of my knowledge. I understand that if I deliberately enter false information on this form, I may receive a $10,000 fine, imprisonment for not more than two years, or both. I also understand that any misrepresentation or concealment of material fact will be sufficient grounds for rejection of my application, removal from any eligibility, or suspension from any Kawerak program participation and services (Sections 20.12, 20.13, and 20.30). Kawerak TWA is authorized to obtain information necessary to establish eligibility for assistance. GA applications that are incomplete will be kept for 30 days. If all required documentation is not received within that time period, your GA application will be denied.

➔ _____ _____ _____ _____

Applicant #1, Signature | Date | Applicant #2, Signature | Date

_____ _____

Printed Name | Printed Name

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## STATEMENT OF NEED

Name: _____ Month: _____

Date: _____ Community: _____

State the reason below why Tribal Welfare Assistance is needed **and** what it is needed for:

Explain below, how you have supported yourself during the past three (3) months and what has changed in your situation to cause you to apply for General Assistance. Include all other information you feel would help us better assist you.

➔ _____ _____ _____ _____
Applicant #1, Signature Date Applicant #2, Signature Date

**OFFICE USE ONLY**

| | | | |
|---|---|---|---|
| ☐ Pend date:_____<br>☐ Approved date:_____<br>☐ Denied date:_____ | ☐ Approved<br>☐ Denied | Voucher # | **Total GA Award**<br>**$** |
| Comments: | | | Date Received: |
| Welfare Specialist signature: | Date: | Other Staff review: | Date: |

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## VOUCHER REQUEST FORM

Name: _____ Month: _____

Date: _____ Community: _____

☐ **I AM THE HEAD OF HOUSEHOLD** ☐ **I LIVE WITH MY PARENTS/GRANDPARENTS/AUNT/UNCLE, etc.**

In 1993, Kawerak instituted vendor payment system that uses vouchers to pay for essential unmet needs. Kawerak does not make direct payments to eligible clients. Vouchers have a thirty (30) day time limit. If eligible, we will mail a payment directly to the vendor. GA can only pay current amounts. Late charges or late fees are not paid. Vouchers will only be mailed to avoid duplications of vouchers.

| | |
|---|---|
| ☐ Pay my rent to:<br><br>Name & Address/Phone:_____<br>_____<br>_____<br>_____<br><br>Amount: $_____<br>**Complete landlord shelter statement attached | ☐ Pay my mortgage to<br><br>Bering Straits Regional Housing Authority or<br>_____<br>_____<br>_____<br><br>Amount: $_____<br>**Attach **current** Mortgage invoice |
| ☐ Pay my utility bill to:<br><br>Name & Address/Phone:_____<br>_____<br>_____<br>_____<br><br>Account #:_____<br><br>Amount: $_____<br>**Attach copy of **current bill**/statement | ☐ Pay my sewer/water to:<br><br>Name & Address/Phone:_____<br>_____<br>_____<br>_____<br><br>Account #: _____<br><br>Amount: $_____<br>**Attach copy of **current bill**/statement |

If approved, for basic needs, we will provide a voucher to your store for authorized purchase items

| | |
|---|---|
| ☐ Pay to the Store for groceries:<br><br>STORE Name & Address/Phone:_____<br>_____<br>_____<br>_____<br>***YOU CANNOT SELL ITEMS YOU PURCHASED WITH GA FUNDS.***<br>Amount: $_____or Percent _____ | ☐ Pay to the Store for groceries/heating fuel:<br><br>STORE Name & Address/Phone:_____<br>_____<br>_____<br>_____<br>***YOU CANNOT SELL ITEMS YOU PURCHASED WITH GA FUNDS.***<br>Amount: $_____or Percent _____ |

I understand that items NOT allowed to purchase with Kawerak GA vouchers include: Alcohol, tobacco products, cosmetics, hair spray, hair coloring, home perms, cat or dog food, sun glasses, gift wrap, ribbons & bows, electric devices such as: stereos, radios, vacuum cleaners, TV, cologne, toys, flowers, plants or potting soil. I understand that **I CANNOT ACCEPT CASH FOR VOUCHERS**. By signing below, I understand I may have to repay the money or I could be charged with Fraud if I don't follow the Kawerak Purchase list. I understand Kawerak will only mail vouchers.

☒_____ _____ ☒_____ _____

Applicant #1, Signature Date Applicant #2, Signature Date

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# INDIVIDUAL SELF-SUFFICIENCY PLAN (ISP) OR CASE PLAN

All Adults in the case need to complete with the Tribal Welfare Coordinator. Call1.800.478.5230 or 443.4370

☐ ISP (ACTIVITIES) / ☐Case Plan (Work Exemption)

Name of Client:_____ Date:_____

What is/are your goals to achieve self-sufficiency?

***Your Short Term Goals***: _____ *(1 year)*

***Your Long Term Goals***: _____ *(5 year)*

| **BARRIERS TO CLIENT** | | | **STRENGTHS OF CLIENT (you complete)** |
|---|---|---|---|
| ☐ Health<br>☐ Mental Health<br>☐ Substance Abuse<br>☐ Age Factors<br>☐ Disabilities | ☐ Lack of/Limited Transportation<br>☐ Lack of/Limited Education<br>☐ Criminal History<br>☐ Limited/No work history<br>☐ No job skills | ☐ No Driver's License<br>☐ Social Isolation<br>☐ Limited/No jobs available<br>☐ Homeless<br>☐ Other | Identify Strengths you possesses: |

## STEPS NEEDED TO ACHIEVE YOUR SELF-SUFFICIENCY

| **Work Activities** | **Education/Training** | **Other Activities** | **Or Case Plan (Medical, etc)** |
|---|---|---|---|
| ☐ Job Search | ☐ High School Diploma | ☐ Life Skills Activities | ☐ SSA Application (Disability) |
| ☐ Volunteer Work Experience | ☐ GED | ☐ Parenting Skills | ☐ Voc Rehab Application |
| ☐ Job Sampling or Job Shadow | ☐ ESL (English as 2nd Language) | ☐ Childcare Assistance | ☐ Work with Behavior Health |
| ☐ On the job training | ☐ Adult Vocational Training | ☐ Child Support | ☐ Medical Report |
| ☐ Employment Counseling | ☐ Literacy Improvement | ☐ Substance Abuse Treatment | ☐ Child under 6 in household |
| ☐ Register at Nome Job Center | ☐ Higher Education | ☐ Counseling | ☐ Legal Assistance |
| ☐ Job Readiness | ☐ Other | ☐ Driver's License Reinstatement | ☐ APA Application |
| ☐ Other: | | ☐ Dental/Health Care | ☐ Other |
| | | ☐ Other | ☒ Attach Health Provider Note |

## SELF SUFFICIENCY ACTION PLAN & GOALS

**Your Goal #1 ↓ (IF YOU ARE ABLE TO WORK)**

**PERFORM WORK SEARCH AND OBTAIN EMPLOYMENT AND ADD GOAL #2 or MEDICAL CASE PLAN –ADD to Goal #2**

| ACTION STEPS FOR GOAL #1 | DATE TO BE ACHIEVED | **Initial below completed** |
|---|---|---|
| 1. Contact the Nome Job Center and register in ALEXsys & create resume | With application | |
| 2.Complete work search form with 3 employers and continue all month | With application | |

**Your Goal #2 ↓ (Add)**

| ACTION STEPS FOR GOAL #2 | DATE TO BE ACHIEVED | **Initial below completed** |
|---|---|---|
| | | |
| | | |

**GA worker's activity (CFR 20.318)**

**1.** Identify the services needed to meet goals above and make referrals

**2.** Monitor participation activities and document activities.

*Initial ↓

*_____ I understand that the purpose of the Individual Self-Sufficiency Plan (ISP) is to meet the goal of employment through specific action steps and I am required to follow the steps developed in the ISP. I understand that I must participate in work activities and/or other activities and referrals developed in this plan that will promote self-sufficiency. Failure to follow through with the ISP may constitute suspension from the Tribal Welfare Assistance Program for a period of at least 60 days but not more than 90 days. I also understand that if there are any changes to be made that I will contact my GA worker in a timely manner to ensure my success in the Tribal Welfare Assistance Program.

*_____ I understand that the purpose of the Case Plan is to follow through my goals listed: (i.e.) accessing other resource programs, keeping medical appt, etc. Failure to follow through with the steps identified in the Case Plan may constitute suspension from the Tribal Welfare Assistance Program.

➔_____ _____ _____ _____

**Applicant Signature** **Date** TWA Staff Signature Date

PLAN REDETERMINATION DATE: _____

**All ADULT applicants** in the household unit must complete this form separately & return to our office.

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# WORK SEARCH FORM/WORK RELATED ACTIVITY SHEET

Name: _____ Month: _____

Date: _____ Community: _____

**General Assistance applicant(s):** Bring this form to employers and apply for jobs. If you are able to work, all eligible adults must apply for a minimum of (3) three different jobs as required to be eligible for services. Have the employer complete below verifying you have applied for a job. Fax this completed Work Search Form with your application to 443.4455, 443-4457 or 1.877.824.4455. If you need more Work Search Forms, contact us at 443.4370 or 1.800.478.5230. If you are unable to work, contact us ASAP. **All able adult applicants in the household must complete this form separately & return with their application for assistance.**

**Employer:** Please complete the information below for the applicant who is pursuing employment with your organization or business.

| **WORK SEARCH/WORK RELATED ACTIVITY #1** | |
|---|---|
| Date: | Job Title/Work Activity: |
| Employer or Business Name: | Employer or Business Phone #: |
| Employer or Business Address: | |
| Submit a complete application? ☐ Yes ☐ No<br>Was applicant offered employment? ☐ Yes ☐ No<br>Did applicant accept employment? ☐ Yes ☐ No | Was applicant interviewed for the job? ☐ Yes ☐ No<br>Did applicant refuse employment? ☐ Yes ☐ No<br>Submit a Resume? ☐ Yes ☐ No |
| Employer/Supervisor Signature: | Employer/Supervisor Printed Name: |
| Comments: | |

| **WORK SEARCH /WORK RELATED ACTIVITY #2** | |
|---|---|
| Date of Work Search: | Job Title/Work Activity: |
| Employer or Business Name: | Employer or Business Phone #: |
| Employer or Business Address: | |
| Submit a complete application? ☐ Yes ☐ No<br>Was applicant offered employment? ☐ Yes ☐ No<br>Did applicant accept employment? ☐ Yes ☐ No | Was applicant interviewed for the job? ☐ Yes ☐ No<br>Did applicant refuse employment? ☐ Yes ☐ No<br>Submit a Resume? ☐ Yes ☐ No |
| Employer/Supervisor Signature: | Employer/Supervisor Printed Name: |
| Comments: | |

| **WORK SEARCH /WORK RELATED ACTIVITY #3** | |
|---|---|
| Date of Work Search: | Job Title/Work Activity: |
| Employer or Business Name: | Employer or Business Phone #: |
| Employer or Business Address: | |
| Submit a complete application? ☐ Yes ☐ No<br>Was applicant offered employment? ☐ Yes ☐ No<br>Did applicant accept employment? ☐ Yes ☐ No | Submit a complete application? ☐ Yes ☐ No<br>Was applicant offered employment? ☐ Yes ☐ No<br>Did applicant accept employment? ☐ Yes ☐ No |
| Employer/Supervisor Signature: | Employer/Supervisor Printed Name: |
| Comments: | |

**All adult applicants** in the household unit must complete this form separately & return with their application.

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I (We), authorize the release of information requested by the Kawerak Inc. or its representatives within the Tribal Welfare Assistance Department. The requested information shall be used solely in the administration of Tribal Welfare Assistance staff and will not be released to any other person or agency outside the Tribal Welfare Assistance Department or its agents without signed authorization from the client.

I (We) hereby authorize the Kawerak, Inc. to obtain and exchange information related to my applications to participate in their programs; and to arrange for such participation based on my employability assessment and plan to employment related activities. This release of information shall be in effect while I'm an applicant or recipient of Tribal Welfare Assistance and for any later investigation pertaining to my eligibility and receipt of Tribal Welfare Assistance benefits.

Persons or organizations that may be contacted include, but are not limited to: All State of Alaska Departments and Divisions, All Federal Agencies and local and Tribal Governments, State of Alaska, Public Assistance Program contractors and grantees, health care providers, tax assessors, DOLWD Job Centers, financial institutions, Native Corporations, stock brokerage firms, landlords, present and past employers, school authorities, private individuals and all departments and programs within and administered by the Kawerak, Inc.

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Applicant #1, Signature | Date | Applicant #2, Signature | Date |
| _____ | | _____ | |
| Printed Name | | Printed Name | |
| _____ | _____ | _____ | _____ |
| Social Security Number | Date of Birth | Social Security Number | Date of Birth |

*A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL*

**KAWERAK, INC. ~ Tribal Welfare Assistance Department**
Education, Employment & Training Division
Tribal Welfare Assistance Department-General Assistance Application
Email: welfare.spec@kawerak.org or welfare@kawerak.org

P.O. Box 948 ~ Nome, AK 99762
Web site: www.kawerak.org
Ph: (907) 443.4370 ~1.800.478.5230
Fax: (907) 443.4485 ~ 1.800.450.4341

## NOTIFICATION TO CLIENT

**The Federal law concerning fraud states…** "Whoever in any matter within the jurisdiction of any department or agency of the United States, knowingly and willingly falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false fictitious or fraudulent statements or representations or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry shall be fined not more than $10,000.00 or imprisoned not more than five years or both."

**Under the Privacy Act, 5 U.S.C. 552(a), Section 7(a)(1)(2),** The WA Program cannot give out the information you give the caseworker with the exception of other Federal, State, Tribal Offices and other programs who have some responsibility for providing the welfare services for which you are applying. The information can also be given to those agencies when you ask them for a job or for some other benefit, and for law enforcement purposes. This can be done without your written release. For any other person or program wanting information from your case record file, you must first give your written consent. You have a right to know what information is inaccurate, ask your caseworker about how to change the information in the case record.

**Paperwork Reduction Act of 1995 S.244** This section of this chapter are to minimize the paperwork burden for individuals, small businesses, educational and nonprofit institutions, federal contractors, State, local and tribal governments and other persons resulting from the collection of information by or for the federal government.

**Tribal Welfare Assistance clients must:** Participate with the Welfare worker in developing an ISP and signing the ISP; Perform successfully in the work search activities during the month GA is received, attend GED studies/classes, community service, or apply for training and/or other employment assistance programs developed in the ISP; Maintain and update the DOLWD ALEXsys registration and resume when work or training status changes, and report any income or changes to the household immediately. If applicable, participate successfully in treatment and counseling services identified in the ISP; Participate in evaluations of job readiness and/or any other testing required for employment purposes; and demonstrate that you are actively seeking employment by providing the Tribal Welfare Assistance Department with evidence of job search activities as required on the ISP.

By signing below, I have read, understand and agree to follow the notifications above.

| Applicant #1, Signature | Date | Applicant #2, Signature | Date |
|---|---|---|---|
| | | | |

| Printed Name | Printed Name |
|---|---|
| | |

| Social Security Number | Date of Birth | Social Security Number | Date of Birth |
|---|---|---|---|
| | | | |

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# NOTICE ABOUT YOUR RIGHTS

## CIVIL RIGHTS

The Civil Rights Act of 1974 states "No person in the United States, on the ground of race, color, or national origin, shall be excluded from participation or be denied the benefits of federal assistance." If you feel you have been discriminated against, you may file a complaint with Kawerak, Inc. or with the United States Department of Health and Human Services.

## FAIR HEARING

Kawerak Welfare Assistance Policies – Appeals Section 6.

§ 5.1 Persons who may appeal. Any individual who has applied for services and been denied, or who claims that the level of service provided was not in compliance with the Kawerak Welfare Assistance policies and procedures or in violation of federal law, may appeal by following the fair hearing process below.

§ 5.2 Fair hearing process. When a client requests a fair hearing, the request must be in writing, signed by the client and submitted to the GA Program Director within 20 days of the action. If the GA Program Director is unable to resolve the situation, the hearing request will be forwarded to Kawerak's EET Vice President for attention and disposition. If the client is dissatisfied with the EET Vice Presidents decision, then (s) he can appeal the decision to Kawerak's President and Board of Directors, which at its discretion may hear the appeal as a full Board of delegate the matter to a Board committee.

Kawerak is available to assist you if you request a hearing. At the hearing you may represent yourself. You may also be represented by legal counsel (e.g. – Alaska Legal Services Corporation or another person of your choice). Kawerak will not provide transportation to and from your hearing.

## AGREEMENT

If your household receives assistance, you must agree to the statement below. Any member of your household who deliberately breaks any rules and receives benefits to which they are not entitled to will be required to pay back the benefits received under false information.

- ☐ I certify that I have checked the information on the application carefully and it is true and has complete facts according to the best of my knowledge and belief.
- ☐ I understand that it is against the law to make false statements and that I am subject to prosecution if I do so.
- ☐ I understand that a Kawerak representative may call my home and may contact other people in order to verify my eligibility for assistance. I also understand that information I give may be verified by computer cross-matching with other agencies.
- ☐ I authorize the Alaska Department of Labor to release to Kawerak, Inc. information about my eligibility for unemployment insurance and work credits.
- ☐ I certify that all my income for this application month has been reported on this application.
- ☐ I certify that I will follow my ISP and work on the steps to reach my goals.
- ☐ I understand that Kawerak's Tribal Welfare Assistance Program does not pay for transportation costs to attend a fair hearing.

| Applicant #1, Signature | Date | Applicant #2, Signature | Date |
|---|---|---|---|
| Printed Name | | Printed Name | |
| Social Security Number | Date of Birth | Social Security Number | Date of Birth |

# KAWERAK, INC.

## TRIBAL WELFARE ASSISTANCE DEPARTMENT

Phone 1.800.478.5230 or 443.4370

## VERIFICATION OF EMPLOYMENT

(Give to employer if you are working or you left your job in the last 60-90 days)

Name: _____ SSN: _____ DOB: _____

Mailing Address: _____

PO Box City/State Zip

---

**★ EMPLOYER, PLEASE COMPLETE THE FOLLOWING INFORMATION ★**

Return via fax to 443-4455 or 443-4457

Employee's Job Position/Title: _____

Hourly Wage: $_____ Bi-Weekly Salary: $ _____ Monthly: $_____

Start/Hire date: _____ Hours per week: _____ Days week: _____

First Pay date: _____ Date of First full pay: _____

Last date check received: _____ amount of check: _____

**(Attach copies of all paychecks for the last 60 days.)**

Is this a Part-Time or Seasonal Job? ☐ Yes ☐ No

If a seasonal position, what are the dates of employment?

Start of Season: _____ End of Season: _____

Is this a Full-Time Permanent Job: ☐ Yes ☐ No

Is the person listed above still currently employed with your company? ☐ Yes ☐ No

***If no, this person: ☐ Resigned ☐ Was asked to resign ☐ Job ended ☐ Terminated ☐ Fired**

Date of final paycheck: _____ (attach a copy of final paychecks for the last 60 days.)

If employment ended, is this person eligible for rehire? ☐ Yes ☐ No

***Please explain reason for end of employment**: _____

_____

_____

Supervisor's Name (please print): _____

Supervisor's Title/Position: _____ Phone: _____

Employer or Company Name: _____

Mailing Address: _____

PO Box or Street City/State Zip

_____ _____

Employers Signature Date

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# LANDLORD/SHELTER STATEMENT

(Complete only if you don't have one on file.)

This form certifies that (Name)_____ resides at the following address:

(Name) _____ has been paying rent to me since (date) _____,

PHYSICAL ADDRESS: _____

_____

_____

and pays: $_____ per month for rent.

Utilities are ☐ Included in rent amount

☐ NOT included in rent amount above, and must share costs:

$_____ Electricity

$_____ Telephone

$_____ Heat/Oil/Fuel

$_____ Water/Sewer

I certify that the above information is correct and true to the best of my knowledge under penalty of perjury or un-sworn falsification.

_____ _____

Signature of Landlord/Manager or Date

Primary Tenant (if renting a room or living with family/friends)

_____ _____

Printed Name Phone number

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# HEALTH PROVIDER NOTE

(GIVE TO HEALTH PROVIDER **IF** YOU ARE UNABLE TO WORK)

Dear Health Provider:

The individual listed below has applied for services from the Kawerak General Assistance Office and has reported a health condition that may interfere with their ability to work. In order to complete the application process for the client, please complete the form below and return to this office, please fax to me at the fax number listed above. A release of information form signed by the client is included with this form. Your timely response is appreciated.

---

Patient Name: _____DOB: _____
Physician/Health Aide/BHS Clinician: _____Phone #: _____

The individual listed above has been evaluated on ___/_____/_____. The physician/health aide/clinician has instructed the individual concerning further work as described below:

1. Does the patient named above have a condition that would limit their ability to work full time or part time?
   ☐ Yes ☐ No -- If no, stop here, sign below and return the form to fax 443-4455
2. Can the patient work in some capacity?
   a. Full time ☐ Yes ☐ No **OR**
   b. Part time ☐ Yes ☐ No If yes, how many hours per day can they work? _____ hours
3. How many months you expect the condition to limit the patient's ability to work? _____ months
4. Check off what the patient can do below:

| | |
|---|---|
| ☐ Standing | ☐ Lifting - up to |
| ☐ Sitting | ☐ Lifting under 10 lbs |
| ☐Walking | ☐ Limits: |
| ☐Repetitive activities | ☐ |

5. Are there any recommendations needed to help this patient function effectively in a work or training environment? ☐ Yes ☐ No If yes, explain:

_____
_____
_____

_____
Physician/Clinic/Clinician/VBC Date

_____
Print Name Contact phone

ALL FAXES RETURNED MUST COME VIA FAX BY THE PHYSICIANS OFFICE, BHS, OR HEALTH CLINIC.

Please fax back to Kawerak Tribal Welfare Office at 443-4455 by: _____