



KAWERAK. INC.

REPRESENTING

Brevig Mission

Sitaisaq

Council

Diomede

Injaliq

Elim

Niviarcaurluq

Gambell

Sivuqaq

Golovin

Chinik

King Island

Ugiuvak

Koyuk

Kuuyuk

Mary's Igloo

Qawiaraq

Nome Eskimo

Sitnasuak Inuit

Savoonga

Sivungaq

Shaktoolik

Saktuliq

Shishmaref

Qikiqtaq

Solomon

Anuutaq

St. Michael

Taciq

Stebbins

Tapraq

Teller

Tala

Unalakleet

Unyalaqtiq

Wales

Kinigin

White Mountain

Igaulik /

Nutchirviq

2025 Adult Driver's Education Application

APPLICANT'S CHECKLIST:

- Statement of Interest: Why are you interested in this training? How will this training assist you in obtaining employment or enhance skills at your current job? See page 3 of application.
- Complete Kawerak Training Application
- Tribal Enrollment Verification (Obtain from your local IRA Office)
- NACTEC Adult Application
- EFT Form & W9

****If you have received services from Kawerak EESS within the last 3 years we may have documents on file.****

ELIGIBILITY CRITERIA

Applicants must meet the following criteria:

1. Must be Alaska Native or American Indian, and a tribal member of a federally recognized tribe.
2. Must be a resident of the Bering Strait region. *Tribal members of Nome Eskimo Community must apply at your local office.*
3. Must be unemployed, under-employed, and possess limited or no job skills. Individuals who require additional training to retain employment or enhance job skills are eligible to apply.
4. Complete the training application and Employment Development Plan (EDP).
5. Applicants must show financial need after having applied for additional funding resources.
6. Must be able to pass a drug test.
7. Must be physically capable.

APPLICATION SUBMISSION:

Scan and email: training@kawerak.org

Fax: (907)802-7806

If you need help with your application or if you have any questions, please contact our Regional Training Specialist at 443-4391 or toll free at 1-(800) 450-4341.

Quyana!

KAWERAK. INC.

PO Box 948 • Nome Alaska 99762 • 907.443.5231 • www.kawerak.org

Advancing the capacity of our people and tribes for the benefit of the region.

Kawerak, Inc. Education, Employment & Supportive Service Division

HE DE SS VT STRT SYP ABE GED ESL CNA AVTEC

Mailing Address: P.O. Box 948 Nome, AK 99762 ~ **Email:** intake@kawerak.org ~ **Phone:**(907)443-4358 **Toll Free:**(800)450-4341 ~ **Fax:**(907)802-6183

Initial Intake & Short Education or Employment Development Plan

Name: _____ Current Age _____
 (First) (Middle) (Last) (Also Known As – or Maiden name)

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____ Gender: Male Female

Present Mailing Address: _____
 (Street Address or P.O. Box) (City) (State) (Zip Code)

Home Phone: _____ Work / Cell: _____ Email Address: _____

Tribally enrolled at: Brevig Mission - Council - Diomed - Elim - Gambell - Golovin - King Island - Koyuk - Mary's Igloo - Nome Eskimo Community - St. Michael - Savoonga - Shaktoolik - Shishmaref - Solomon - Stebbins - Teller - Unalakleet - Wales - White Mountain - Other?

Veteran? Yes No - Date of Discharge: ____/____/____ **Registered with Selective Service?** Yes No

Educational Status: High School Diploma - Year Graduated: _____ GED - Year obtained _____ OR Highest Grade Completed: _____
 College/Vocational Graduate - Type of Degree: Certificate AA/AAS BA/BS MA/MS Other: _____ Year _____

Most Kawerak EESS programs and/or jobs are subject to drug testing. **Are you willing to take a drug test?** Yes No

Applicant Ethnicity:	Applicant Primary Goal: (check one)	Education/Employment Service Needs List:
(check all that Apply) <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Other (specify): _____ Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single/Separated <input type="checkbox"/> Living with Partner <input type="checkbox"/> Divorced/Widowed	<input type="checkbox"/> Obtain or Improve a Job <input type="checkbox"/> Retain Current Job <input type="checkbox"/> Self-employment <input type="checkbox"/> Earn a High School Diploma or GED <input type="checkbox"/> Enter Postsecondary Education or Job Training <input type="checkbox"/> Educational Gain <input type="checkbox"/> Obtain Driver's License <input type="checkbox"/> Commercial Driver's License <input type="checkbox"/> Subsistence Activities (carving, beading, sewing, etc.) <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Relocation Assistance for Employment <input type="checkbox"/> Housing Assistance <input type="checkbox"/> Transportation To/From Training or Job <input type="checkbox"/> Enter Postsecondary Education or Job Training <input type="checkbox"/> Child Care <input type="checkbox"/> Training Fees or Tuition <input type="checkbox"/> Work Attire or On The Job Clothing <input type="checkbox"/> Other (Specify): _____

Applicant Status and Program Enrollment

Applicant Primary Status	Barriers to Education/Employment	Institutional Programs
(Check All That Apply) <input type="checkbox"/> Disabled <input type="checkbox"/> Employed <input type="checkbox"/> Worked 90 days or more - this calendar year <input type="checkbox"/> Unemployed → <input type="checkbox"/> Collecting Unemployment <input type="checkbox"/> Not in the Labor Force <input type="checkbox"/> On Public Assistance ← (ATAP, TANF, food stamps, tribal welfare assistance)	(Must Complete) Last or Current hourly wage: \$ _____ Unemployed since: ____/____/____ (currently on or received in last six months)	(Check All That Apply) <input type="checkbox"/> In Correctional Facilities (AMCC, Seaside, etc.) Release date _____ <input type="checkbox"/> In Other Institutional Settings (A.P.I., Substance Treatment, etc.) Release date _____ <input type="checkbox"/> None of the above

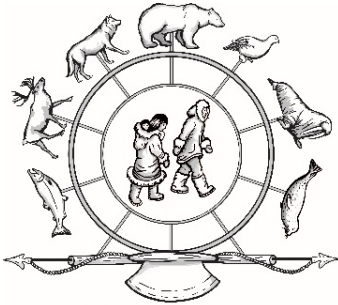
I certify that the information given on this application is true to the best of my knowledge. By signing my name, I agree to allow information from this form to be used for statistical and follow-up purposes. I understand that my name will never be used in any report and that all data will be kept strictly confidential.

Print Name: _____ Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

FOR OFFICE USE ONLY: Date Received: _____ Date Entered: _____ Initials: _____

Revised 05/8/2018



KAWERAK, INC.

KAWERAK, INC.

Education, Employment, and Supportive Services

P.O. Box 948, Nome, AK 99762

Toll Free: 1-800-450-4341 Phone: 907-443-4358 Fax: 907-802-6183

Email: intake@kawerak.org Website: www.kawerak.org

Supplemental Information Forms

First Name:	MI:	Last Name:
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LIST ALL PEOPLE LIVING IN THE HOUSEHOLD: (spouse, boyfriend, girlfriend, partner, roommates, children, parents, grandparents, aunts, uncles, cousins, etc.)

Name:	Relationship:	Date of Birth	Social Security #	Employed (circle one)	Monthly Income, Including Unemployment Benefits
				Y/N	
				Y/N	
				Y/N	
				Y/N	
				Y/N	
				Y/N	
				Y/N	
				Y/N	
				Y/N	
				Y/N	
TOTAL INCOME					

HOUSEHOLD TYPE: Own Mortgaged Rental Relatives Other:

ECONOMIC STATUS: Please check is you or family members listed above receive any of the following

- | | |
|--|---|
| <input type="checkbox"/> State of Alaska ATAP/TANF
<input type="checkbox"/> Tribal Welfare Assistance
<input type="checkbox"/> Food Stamps/SNAP
<input type="checkbox"/> Supplemental Security Income (SSI)
<input type="checkbox"/> Social Security Disability Insurance (SSDI) | <input type="checkbox"/> Heating Assistance (LIHEAP)
<input type="checkbox"/> Military Income (Veterans Benefits)
<input type="checkbox"/> Child Support
<input type="checkbox"/> Seniors Assistance
<input type="checkbox"/> Subsidized Employment |
|--|---|

LIST TOTAL MONTHLY EXPENSES: (Proof of Expenses may be Requested of Applicant)

Rent/Mortgage	\$	Home Phone	\$
Food	\$	Cell Phone	\$
Electricity/Utilities	\$	Cable	\$
Water/Sewer	\$	Internet	\$
Heating Fuel	\$	Other	\$
Propane	\$	Other	\$
Total	\$	Total	\$

EMPLOYMENT HISTORY or SELF-EMPLOYMENT

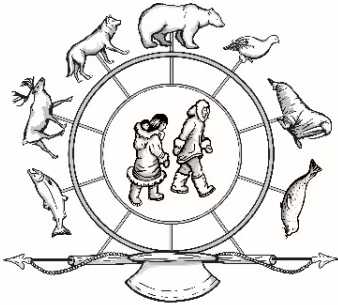
Job Title:	Start Date:	End Date:
Employer:	Phone #:	Wage:
Reason for Leaving:		
Duties:		
Job Title:	Start Date:	End Date:
Employer:	Phone #:	Wage:
Reason for Leaving:		
Duties:		

STATEMENT OF NEED

****DO NOT LEAVE BLANK**** What are your employment goals and what assistance are you are requesting?

I hereby certify that all the information listed above is true and correct. I understand that submitting misleading or falsifying information to gain benefits are grounds for denial of services and may lead to prosecution, fines, and imprisonment. I understand my name will never be used in any report and that all data will be kept strictly confidential within Kawerak. I have read and understand my rights and responsibilities.

Print Name: _____ Sign: _____ Date: _____



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Education, Employment, and Supportive Services

P.O. Box 948, Nome, AK 99762

Toll Free: 1-800-450-4341 Phone: 907-443-4358 Fax: 907-443-4485

Email: intake@kawerak.org Website: www.kawerak.org

AUTHORIZATION OF RELEASE OF INFORMATION

(Valid for no less than 24 Months)

I hereby authorize the release of any and all information needed by Kawerak, Inc. for the use and determination of eligibility for financial assistance through the Education, Employment, and Supportive Services Division and for exchange of information for the Education or Employment Development Plan and career guidance services.

Persons or organizations that may be contacted include, but are not limited to: State of Alaska: Department of Labor and Workforce Development; Department of Public Assistance; Social Security Administration; Local Governments; City Councils; Village Councils; Native Corporations; State, Federal, and Private Educational organizations; Financial Institutions; Landlords, Employers, School Districts; Businesses and Private individuals.

I hereby authorize the use or disclosure of my personal and protected information described below but may not be all inclusive.

Birth Certification Social Security Card Verification of Tribal Enrollment Employment Pay Stubs

Verification of Selective Service Verification of Employment Verification of Residency

Verification of Public Assistance or Unemployment from the State of Alaska

Verification of Education Diploma, Degree, or Certificate Other: _____

I understand that this authorization is voluntary. I understand that my records may contain sensitive information. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization. This authorization expires 2 years from the date of signature.

Signature of Applicant

Date

Print Name

Date of Birth

IF UNDER 17 Years of Age: Signature of Parent or Guardian

Date

Print Name

Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____	
	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>	
	5 Address (number, street, and apt. or suite no.)	
	Requester's name and address (optional)	
	6 City, state, and ZIP code	
7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number									
				-			-		
or									
Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

KAWERAK, INC.
VENDOR PAYMENT AGREEMENT

AUTHORIZATION FOR VENDOR PAYMENT

VENDOR NAME : _____

MAILING ADDRESS: _____

VENDOR EMAIL: _____

VENDOR PHONE: _____

PAYMENT METHOD: (INITIAL)

____ - ACH TRANSFER**Please fill out Bank information and sign below

____ - PHYSICAL CHECK **Please sign below, Kawerak we will not reissue physical payments for 60 days

DEPOSITORY (bank) NAME: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Checking/Savings (CIRCLE ONE)

TRANSIT ROUTING#: _____

ACCOUNT #: _____

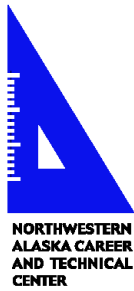
I (we) hereby authorize KAWERAK, Inc. to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to: Checking or Savings Account indicated above and the depository named above, called DEPOSITORY.

This authority is to remain in full force and effect until Kawerak, Inc. has received written notification from me of its termination.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

Attach voided check below line, if possible, before emailing to finance@kawerak.org



Adult Training & Facility Usage Application

DEMOGRAPHIC INFORMATION									
<i>Please provide all requested information</i>									
<i>This information is used for record-keeping purposes to comply with state grant requirements. NACTEC restricts the sharing of information to organizations supporting workforce development training programs at NACTEC.</i>									
Training/Activity:									
Training Date(s):					NACTEC Point of Contact:				
SOCIAL SECURITY #			LAST NAME			FIRST NAME			MI
MAILING ADDRESS				CITY		STATE		ZIP CODE	
EMAIL ADDRESS:					GRADE LEVEL (Identify highest level completed):				
CONTACT PHONE									
Are you Hispanic/Latino?			Citizen Status (Please check only one)				DATE OF BIRTH		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	United States Citizen		Month	Day	Year
Race (Check one or more)			<input type="checkbox"/> Permanent Resident Alien						
<input type="checkbox"/>	Alaska Native		<input type="checkbox"/> Refugee/Parolee						
<input type="checkbox"/>	American Indian		<input type="checkbox"/> Temporary Work				GENDER		
<input type="checkbox"/>	Asian		<input type="checkbox"/> Other				<input type="checkbox"/> Male	<input type="checkbox"/> Female	
<input type="checkbox"/>	Black/African American		Do you wear corrective lenses? (Please check one)						
<input type="checkbox"/>	Hawaiian Native or Other		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/> Unsure if needed		
<input type="checkbox"/>	Pacific Islander		Are you an Alaskan Resident? (Please check one)						
<input type="checkbox"/>	White/Caucasian		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No			
MILITARY AFFILIATION									
Are you currently in the U.S. Military or a Veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>					Are you the spouse of a member of the armed forces who is on active duty? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Are you the spouse of a veteran who has a permanent, total service-connected disability or had the disability at the time of death, or died while the disability was in existence?									
OR: A spouse of a service member on active duty who died or has been Missing In Action (MIA), captured in the line of duty or forcibly detained for a total of more than 90 days?									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
Emergency Contact Information:									
<i>Provide the name and a contact number for a relative or individual who should be contacted in case of emergency.</i>									
Last Name			First Name			Relationship		Telephone	
<i>NACTEC is an equal opportunity employer and program administrator. Auxiliary aids and services are available upon request to individuals with disabilities.</i>									

HEALTH & SAFETY INFORMATION		
Do you have any physical conditions requiring accommodations or awareness? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have allergies, diabetes, or epilepsy? Identify & list medication (if any):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other medical conditions that could impact your training? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

User Agreement

- Safety is a number one priority** while on NBHS campus and in NACTEC-supported training. I will exercise caution and be responsible for my own personal safety and well-being in the training and residential facilities. (_____) *Initial here*
- NACTEC maintains a ZERO TOLERANCE POLICY:**
Drugs, alcohol, and tobacco are not permitted on campus, and at any time during NACTEC-sponsored training. If I am found using, under the use, or in possession of drugs, alcohol, or tobacco I understand I will be removed from training. (_____) *Initial here*

APPLICANT AUTHORIZATION SIGNATURE
<ul style="list-style-type: none"> I certify to the best of my knowledge that the information in this application is accurate, true, verifiable, and subject to verification. I understand that the answers I have provided in this application are considered self-attestation, and I may be asked to provide proof to support my answers. I understand this information is necessary for record-keeping purposes to comply with state grant requirements. I certify that I am an Alaska resident, and I intend to stay in Alaska and make it my home. I agree to the use of the personally identifiable data collected on this form, including my Social Security number, for use by the Alaska Department of Labor to measure the performance and outcomes of the activities conducted under the AWIB. In the event of an emergency, and the emergency contact listed can not be reached, permission is hereby granted to a licensed physician or accredited hospital and their associates to perform any medical and/or surgical procedures that are deemed essential to the treatment. <p>I, DO <input type="checkbox"/> DO NOT <input type="checkbox"/>, grant the State of Alaska and all its administrative subdivisions the irrevocable right to use my likeness, comments, or personal story or all in media presentations, any of which may be reproduced and publicly distributed in media such as in photographs, videos, advertisements, and newspaper and magazine articles for public information, marketing, or policy discussions. This release is unconditional. I waive any right that I may have to inspect and approve the image or commentary that may be used. I release the State of Alaska and its administrative subdivisions from any claim(s) for compensation associated with using these images and/or commentaries.</p> <p>Applicant Signature: _____ Date: _____</p>