



Kawerak, Inc. Education, Employment & Supportive Services Division
 Tribal Welfare Assistance Department – Emergency Assistance Program
 P.O. Box 948, Nome, AK 99762 ♦ Toll Free: 1-800-478-5230 ♦ Phone: 907-443-4370 or 907-443-4367
 Fax: 907-308-6934 ♦ Email: welfare@kawerak.org ♦ Website: www.kawerak.org

Emergency Assistance Application

The Kawerak Emergency Assistance (EA) Program is a *last resort* program for **low-income individuals or families whose homes have been destroyed**. In order to be eligible, the damage must have already occurred. These services are for essential needs and other non-medical necessities (up to a maximum of \$1,000 per house or apartment). Vendors are paid directly.

Prior to applying for Kawerak, Inc.'s Emergency Assistance Program, applicants must contact the Red Cross at 1-800-733-2767 and request assistance.

Eligibility Criteria

- Applicants must provide proof their home was destroyed. This home must be their primary residence.
- The destruction must be verified by local authorities or tribal staff members.
- Applicants must indicate the time, date and who they spoke with at the Red Cross to request assistance.
- Applicants must provide proof of Tribal enrollment in a federally recognized tribe and meet residency requirements.

Tribal Enrollment and Residency

1. Tribal members of Nome Eskimo Community and federally recognized tribes that are located outside of the Bering Strait Region *who reside in Nome* must apply for Emergency Assistance through Nome Eskimo Community (NEC) per Section 4 of NEC's Tribal Redesign Plan.
2. All tribal members of federally recognized tribes *who reside in Unalakleet* must apply for Emergency Assistance through the Unalakleet IRA Office.
3. All other tribal members residing in Nome and other communities in the Bering Strait Region must apply for Emergency Assistance through Kawerak.

Destruction Type

My home was destroyed by (check all that apply):

<input type="checkbox"/> Fire	<input type="checkbox"/> Flood	<input type="checkbox"/> Wind	<input type="checkbox"/> Erosion
<input type="checkbox"/> Black Mold	<input type="checkbox"/> Explosion	<input type="checkbox"/> Sink Hole	<input type="checkbox"/> Infestation

American Red Cross Contact Verification

Time Contacted: _____ Date Contacted: _____ Person Contacted: _____
 Comments: _____

Important Agency Information

Agency	Phone	Fax	Website and/or Email
American Red Cross	1-800-733-2767/opt. 4		https://www.redcross.org/get-help.html
Nome Eskimo Community	(907) 443-2246	(907) 443-9144	https://www.necalaska.org/
Unalakleet IRA Office	(907) 624-3622/ext. 30	(907) 624-3621	E: tracy.cooper@unkira.org
Cook Inlet Tribal Council (Anchorage Residents)	(877) 985-5900	(907) 793-3422	https://citci.org/
Bering Straits Native Corporation	(907) 443-5252	(907) 443-2985	https://beringstraits.com/
Sitnasuak Native Corporation	(907) 387-1200	(907) 443-6437	https://snc.org/
Bering Sea Women's Group	907-443-5444	907-443-3748	E: execdir@nome.net
Nome Emergency Shelter Team	(907) 443-5259	(907) 443-2990	https://www.nomecc.org/nome-emergency-shelter-team.html



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Applicant Information

Name: _____
 (First) (Middle Initial) (Last) (Also Known As or Maiden Name)

Date of Birth: ____/____/____ Monthly Income: _____ Household Size: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

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

Address of Destroyed Home: _____
 (Street Address) (City) (State) (Zip Code)

Emergency Information

Please describe how your home was destroyed and what was lost:

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 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. Kawerak Tribal Welfare Assistance staff are authorized to obtain the information necessary to establish eligibility for assistance. Emergency Assistance applications that are incomplete will be kept for 30 days. If all required documentation is not received within that time period, my Emergency Assistance application will be denied.

 Applicant Signature Date Spouse Signature (if applicable) Date

 Printed Name Printed Name

For Office Use Only

<input type="checkbox"/> Approved Date: _____	CIF#: _____	Total EA Award: \$
<input type="checkbox"/> Pending Date: _____	<input type="checkbox"/> Denied Date: _____	

Comments: _____

WA Staff Signature #1: _____	Date: _____	WA Staff Signature #2: _____	Date: _____
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AUTHORIZATION FOR RELEASE OF INFORMATION

I (We), _____ authorize the release of information to Kawerak Inc., or its representatives within the Emergency Assistance Program. The requested information shall be used solely in the administration of Emergency Assistance and will not be released to any other person or agency outside the Emergency Assistance Program or its agents.

I (We) hereby authorize Kawerak, Inc. to obtain and exchange information related to this application to participate in other programs. This release of information shall be in effect while I'm an applicant or recipient of Emergency Assistance and for any later investigation pertaining to my eligibility and receipt of Emergency Assistance benefits.

Persons or organizations that may be contacted include, but are not limited to: the American Red Cross, All State of Alaska Departments and Divisions, All Federal Agencies and local and Tribal Governments, Public Assistance Program contractors and grantees, health care providers, tax assessors, 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 Kawerak, Inc.

Applicant Signature

Date

Printed Name



Kawerak, Inc. Education, Employment & Supportive Services Division
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Emergency Assistance Vendor Payment Request

Dear Applicant - Kawerak pays vendors directly for essential needs and non-medical necessities.

Applicant Name: _____

Pay my (our) **hotel stay** to:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

****Please attach any related documents if available.***

Pay my **plane ticket** to:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

****Please attach desired itinerary.***

Pay my **noncommercial lodging** to:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

****Please attach any related documents if available.***

Pay to **store #1:**

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

Pay to **store #2:**

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

Pay to **other vendor:**

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

****Please attach any related documents if available.***

I understand that all alcohol, tobacco, and cannabis products **cannot** be purchased with Emergency Assistance Program funds. I also understand I cannot accept cash for items purchased with these funds and doing so may result in fraud charges.

Signature

Date