



Kawerak, Inc. Education, Employment & Supportive Services Division

Tribal Welfare Assistance Department – General Assistance Application

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

General Assistance Program Application

The Kawerak General Assistance Program assists qualifying Tribal members residing in the Bering Strait Region with the following basic needs:

1. Food – This can be food directly from a local store or supplies to acquire food through subsistence activities.
2. Clothing – This can be ordinary clothing, special clothing for work and/or specific clothing needed for subsistence activities.
3. Shelter – This can be assistance with a rent or house payment.
4. Utilities – This can be assistance with electricity, water, sewer, heat, or other utilities.
5. Other Basic Necessities – This can be hygiene or cleaning supplies.

The goal of the General Assistance Program is to help eligible applicants increase self-sufficiency through an Individual Self-Sufficiency Plan, or a Case Plan if the applicant is unemployable due to certain circumstances listed on page 6 of this application.

Eligibility Criteria

- Applicants must not have enough income or other resources to meet basic needs. This program follows the Bureau of Indian Affairs (BIA) current Need Standards of Assistance for Alaska. Please call the phone numbers listed above for more information.
- Applicants must provide proof of residency in the Bering Strait Region (30 day minimum in region). Exceptions can be made for individuals coming home from medical treatment, behavioral health treatment, State protective custody, or incarceration.
- Applicants must be willing to complete an initial intake assessment with a Tribal Welfare Assistance staff member.
- Applicants must also apply for all programs for which they may be eligible.
This may include but is not limited to; the State of Alaska General Relief Assistance (GRA), the State of Alaska Adult Temporary Assistance Program (ATAP) also known as Temporary Assistance to Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), Social Security Benefits, Veterans Benefits, Senior Benefits, Adult Public Assistance (APA) and Unemployment Insurance Benefits (UIB).
- Applicants must not already be receiving ATAP or Supplemental Security Income (SSI).
- Applicants must be actively seeking employment unless exempted due to certain circumstances, please see page 6 for details.
- Applicants must provide proof of Tribal enrollment in a federally recognized tribe and meet residency requirements.

Tribal Enrollment and Residency Information

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 General 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 General 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 General Assistance through Kawerak.

* You may not be eligible if you quit a job or refused a job offer within the last 90 days for reasons within your control.



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Application Checklist

The following documents or information are required in order to complete this application:

- General Assistance Program Application** – Complete the application and attach all relevant documents, then fax or email the completed application to the numbers or email address at the top of this page before the 10th of the month.
- Proof of Tribal Enrollment** – see your Tribal Office for assistance
- All Savings and Checking Account Statements** – for the past 30 days
- Copies of Current Bills** – You must provide copies of current bills in your name. We cannot assist with cut off notices, past due bills, loans, late fees or credit card payments.
- Verification of Residency** – this can be a rent receipt, bill, bank statement, valid driver's license, insurance card, or voter registration
- Proof of All Sources of Income** – check stubs, paperwork from the Alaska Division of Public Assistance (DPA), Child Support, Supplemental Security Income (SSI), Unemployment Benefits, Senior Benefits
- Proof of Application for Other Benefits** – This only includes benefits you may qualify for, such as unemployment benefits, senior benefits, veterans' benefits, social security benefits, public assistance, housing assistance, utility assistance, etc... Applicants must show there are no other resources available to assist with these unmet needs. Applicants will be required to apply for the State of Alaska's Temporary Assistance Program (ATAP) if they are the parents or legal guardians of children under 18 years of age who live with them. All applicants must apply for or be receiving assistance from the Supplemental Nutrition Assistance Program (SNAP) formerly known as Food Stamps with the State of Alaska.

Case Management

1. If you are traditionally or legally married, live together *and* your spouse meets tribal enrollment and residency requirements you can apply on the same application.
2. If you fax this application, please call us at the numbers listed on the top of this page to verify the fax came through. Incomplete applications will not be processed. Any General Assistance applications received after the 10th are considered late applications with an 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.
3. An eligibility decision will be made on the completed, signed application within 30 days of the application date. When determining eligibility for the program, a Tribal Welfare Assistance staff member may contact your current/former employer, Public Assistance, Unemployment office, Nome Job Center, IRA, Bingo/Pull Tabs, City office & other agencies to verify the information you report in your application. We may also call others in your community if the information reported is questionable. If you are eligible for this program a determination letter will be mailed, emailed, or faxed to you.
4. The General Assistance Program pays vendors directly. You will receive a payment request form to keep track of your benefits.
5. You must agree to follow the steps in your Individual Self-Sufficiency Plan (ISP) or Case Plan. Each adult in the case must complete a separate ISP or Case Plan and separate work searches if they are employable. If there are no jobs available, eligible applicants may be required to attend appropriate training as part of their ISP. If eligible applicants are unable to work or attend training due to certain circumstances listed on page 6 of this application, they may be required to complete specific tasks as part of their Case Plan.
6. This application is required once every year. A shortened Monthly Eligibility Redetermination Form is required for each subsequent month.



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Important Agency Information			
Agency	Phone	Fax	Website and/or Email
Alaska Division of Public Assistance ATAP, SNAP, GRA, Medicaid, Senior Benefits, APA	(800) 478-2236 (907) 443-2237	(888) 574-2307 (907) 443-2307	http://dhss.alaska.gov/dpa
Dept. of Labor and Workforce Development Nome Job Center	(800) 478-2626 (907) 443-2626/2460	(907) 443-2810	https://labor.alaska.gov/ E: nome.jobcenter@alaska.gov
State of Alaska Unemployment Office (10am – 3pm)	(888) 252-2557	(907) 465-5573	E: workerscomp@alaska.gov
State Heating Assistance Program	(800) 470-3058	(888) 282-3319	E: liheap@alaska.gov
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/
RuralCap Home Improvements Weatherization, Senior Access, Modification & Upgrades	(907) 279-2511	(907) 278-2309	https://ruralcap.org/client-services/housing/
Bering Straits Regional Housing Authority Emergency Utility Assistance & Housing Preservation	(800) 478-5255	(907) 443-8652	https://www.bsrha.org/
Kawerak Education, Employment & Supportive Services Division	(800) 450-4341	(907) 802-6183	https://kawerak.org (Click on Programs)
Kawerak Vocational Rehabilitation Program (for people with disabilities seeking employment)	(877) 759-4362	(907) 443-4362	https://kawerak.org (Click on Programs)
Kawerak Community Education Department AE, GED, ESL, Higher Education, Summer Youth	(907) 443-4468	(907) 802-6183	https://kawerak.org (Click on Programs)
Kawerak Employment and Training Programs	(907) 443-4371	(907) 802-6183	https://kawerak.org (Click on Programs)

Applicant(s) Information	
Your Name: _____ (First) (Middle) (Last) (Also Known As or Maiden name)	
Date of Birth: ____/____/____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security #: _____	
Your Spouse's Name (if applicable): _____ (First) (Middle) (Last) (Also Known As or Maiden name)	
Date of Birth: ____/____/____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security #: _____	
Home Phone: _____ Cell: _____ Email Address: _____	
Present Mailing Address: _____ (Street Address or P.O. Box) (City) (State) (Zip Code)	
Are you a veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes – Discharge Date: _____	Are you registered with Selective Service? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A



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Household Types

There may be several people living in one house who would be considered separate “heads of household” or “households” and qualify for General Assistance. In this instance separate applications will be required.

The following are types of households:

- (1) Adult Only – an individual who has no dependents. If two people are traditionally or legally married, both may apply on one application. If two people are not married, separate applications are required.
- (2) One Parent Who is Able to Work – a parent who has dependent children and is able to work. This parent has exhausted 60 months of ATAP through the Alaska Division of Public Assistance (DPA) and written verification can be provided from DPA.
- (3) Two Parents Where One Parent is Medically Exempt and Not Able to Work – one parent is medically exempt and he or she is considered physically or mentally unable to perform gainful activity. A physician or other licensed medical professional certifies the exemption and provides a written statement. The parents have exhausted 60 months of ATAP through DPA and written verification can be provided from DPA.

Household

- Household Type (see above):
- Adult Only One Parent Who is Able to Work
- Two Parents Where One Parent is Medically Exempt (Not Able to Work)

**Please list only the people living in your household as described above.*

Full Legal Name	Relationship	Date of Birth	Age	Highest Grade Completed	Tribally Enrolled To (if applicable)
	Self	____/____/____			

Living Arrangement (Check one or write in “Other”)

- Private Residence Correctional Facility – Release date: _____ Group Home (e.g. BSWG, etc.)
- Nursing Home Inpatient Treatment Facility – Release date: _____ Pre-Maternal Home/Patient Hostel
- Homeless Other: _____



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Tribal Enrollment

I am Tribally enrolled with:

- | | | |
|---|--|--|
| <input type="checkbox"/> Native Village of Brevig Mission | <input type="checkbox"/> Native Village of Council | <input type="checkbox"/> Native Village of Diomedede |
| <input type="checkbox"/> Native Village of Elim | <input type="checkbox"/> Native Village of Gambell | <input type="checkbox"/> Chinik Eskimo Community (Golovin) |
| <input type="checkbox"/> King Island Native Community | <input type="checkbox"/> Native Village of Koyuk | <input type="checkbox"/> Native Village of Mary's Igloo |
| <input type="checkbox"/> Native Village of Savoonga | <input type="checkbox"/> Native Village of Shaktoolik | <input type="checkbox"/> Native Village of Shishmaref |
| <input type="checkbox"/> Village of Solomon | <input type="checkbox"/> Native Village of St. Michael | <input type="checkbox"/> Stebbins Community Association |
| <input type="checkbox"/> Native Village of Teller | <input type="checkbox"/> Native Village of Wales | <input type="checkbox"/> Native Village of White Mountain |
| <input type="checkbox"/> Nome Eskimo Community – Residing in the community of: _____ | | |
| <input type="checkbox"/> Native Village of Unalakleet – Residing in the community of: _____ | | |
| <input type="checkbox"/> Other: _____ Residing in the community of: _____ | | |
| (List Tribe Here) | | |

*Please also indicate spouse's Tribal enrollment and residency here if applying on the same application.

Income

List income that you and your spouse (if applicable) received during the last 30 days and current available funds. Attach check stubs if applicable.

Source of Income	Applicant	Applicant's Spouse (if applicable)	Month & Who Received Income
Wages (Net Salary Income)	\$	\$	
Unemployment Insurance Benefits (UIB)	\$	\$	
Public Assistance (ATAP, GRA, APA)	\$	\$	
Supplemental Nutrition Assistance Program (SNAP)	\$	\$	
Senior Benefits	\$	\$	
Veteran's Administration (VA) Benefits	\$	\$	
Federal Tax Refund	\$	\$	
Board Member Stipend	\$	\$	Name of Board:
Profit from a Business (Carving, Beading, Baking, etc.)	\$	\$	
Child Support	\$	\$	
Alimony	\$	\$	
Supplemental Security Income (SSI)	\$	\$	
Social Security Disability Insurance (SSDI)	\$	\$	
Social Security Retirement Benefits	\$	\$	
Social Security Survivors Benefits	\$	\$	
Native Corp Dividends that Exceed \$2,000	\$	\$	Name of Corp:
Bingo, Pull Tab or Other Gaming Winnings	\$	\$	
Other Income (please specify)	\$	\$	
Total Income for Last 30 Days	\$	\$	



Available Cash Resources

The following resources will be disregarded when determining eligibility for General Assistance.

1. The first \$2000 of liquid asset (cash) resources available to household
2. All other resources excluded by federal statute, such as Alaska Native allotments and dividends from for-profit Native Corporations under \$2,000 per annum per public law 100-241 (A)
3. Any fish, game or plant resources obtained through subsistence activity or reindeer husbandry for personal consumption, crafts, or in-kind customary trade

Current Resources	Applicant	Applicant's Spouse (if applicable)	Shared Account?	Month
Checking Account Balance	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Savings Account Balance	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lump Sum Payments (Social Security, VA, Retirement)	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Resources (please specify)	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Total Current Resources	\$	\$		

Monthly Expenses (please list averages)

Rent or Mortgage	\$	Childcare	\$	Basic Necessities (cleaning, hygiene, etc...)	\$
Utilities	\$	Heating Fuel	\$	Other (please specify)	\$
Phone & Internet	\$	Clothing	\$	Total Monthly Expenses	\$

Employability

Please check all that apply:

- I am employable – Please complete the attached **Individual Self-Sufficiency Plan** and **Work Search Form**.
- I am not employable – Please complete the attached **Case Plan** and mark the reason(s) why you are not employable below.
 - I am younger than 16 years of age.
 - I am a full-time student under the age of 19 attending elementary, secondary, or equivalent school.
 - I have a temporary or permanent medical condition that is serious enough to prevent me from working.
 - Please attach a completed **Health Provider Note**.
 - I am caring for someone who is ill on a continuous basis.
 - I personally provide full-time care for a child under six years of age.
 - I live in the same household with my minor child, as well as the other parent of this child and the other parent is not exempt from work requirements.
 - Employment is not accessible to me because of the long commuting time (over one hour each way).

Spousal Information – please check all that apply if your spouse is applying on this application with you.

- My spouse is employable
 - Please have your spouse complete the attached **Individual Self-Sufficiency Plan** and **Work Search Form**.
- My spouse is not employable
 - Please have your spouse complete the attached **Case Plan** and mark the reason(s) why they are not employable.
 - My spouse is a full-time student under the age of 19 attending elementary, secondary, or equivalent school.
 - My spouse has a temporary or permanent medical condition that is serious enough to prevent them from working.
 - Please attach a completed **Health Provider Note**.
 - My spouse is caring for someone who is ill on a continuous basis.
 - My spouse personally provides full-time care for a child under six years of age.
 - Employment is not accessible to my spouse because of the long commuting time (over one hour each way).



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Statement of Need

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 Signature Date Spouse Signature (if applicable) Date

Printed Name Printed Name

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. Kawerak Tribal Welfare Assistance staff are authorized to obtain the 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, I understand my GA application will be denied.

Applicant Signature Date Spouse Signature (if applicable) Date

Printed Name Printed Name

For Office Use Only

Approved Date: _____ CIF#: _____ Total GA Award: _____
 Pending Date: _____ Denied Date: _____ \$ _____

Comments:

WA Staff Signature #1: _____ Date: _____ WA Staff Signature #2: _____ Date: _____



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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 7.

§ 7.1 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.

§ 7.2 Fair hearing process. When a client requests a fair hearing, the request must be in writing, signed by the client and submitted to the TWA Program Director within 20 days of the action. If the TWA Program Director is unable to resolve the situation, the hearing request will be forwarded to Kawerak’s EESS Vice President for attention and disposition. If the client is dissatisfied with the EESS Vice President’s 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 or 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.

NOTIFICATION TO APPLICANT

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 consent. 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 The sections 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. Kawerak has this act available and attached to this application.

By signing below, I understand and have read or explained to me the Federal Law concerning Fraud, provision of my protection under the Privacy Act and the Paperwork Reduction Act.

_____	_____	_____	_____
Applicant Signature	Date	Spouse Signature (if applicable)	Date
_____	_____	_____	_____
Printed Name		Printed Name	



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AUTHORIZATION FOR RELEASE OF INFORMATION

I (We), _____ authorize the release of information to Kawerak Inc., or its representatives within the General Assistance Program. The requested information shall be used solely in the administration of General Assistance and will not be released to any other person or agency outside the General 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 General Assistance and for any later investigation pertaining to my eligibility and receipt of General 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, 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	Spouse Signature (if applicable)	Date
_____		_____	
Printed Name		Printed Name	



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Individual Self-Sufficiency Plan

Dear Applicant,

The goal of the General Assistance Program is to help you become self-sufficient. The purpose of this plan is to help you determine the steps that are needed to achieve the goal of self-sufficiency through employment. Please complete this form if you are **able to work** and not excused from work activities due to the reasons listed on page 6 of the General Assistance Program Application. This plan is required to complete your initial eligibility determination. Please attach additional pages as needed.

Applicant Name: _____ Date: _____

Your Goals – Please list your goals to achieve self-sufficiency below.

Your Short Term Goals (1 Year):

Your Long Term Goals (5 Years):

Your Strengths – Please list your abilities, skills, and work-related experience below. This can include any experience you may have with self-employment through subsistence activities and self-employment through a small business. Please also feel free to list any other strengths you may have. This can include strong connections to family and friends, educational experiences, training, etc.

Strengths:

Your Barriers to Self-Sufficiency – Please list or mark all the circumstances that are making it difficult to achieve self-sufficiency.

- Limited Job Skills
- Limited Education
- Limited Work History
- Limited Available Jobs
- Criminal History
- No Driver's License
- No Birth Certificate
- No Social Security Card

- Lack of Adequate Housing
- Limited Childcare
- Limited Transportation
- Limited English Proficiency
- Physical Health Problems
- Mental Health Problems
- Chemical Dependency
- Other Disabilities

Other Barriers (please explain):



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Steps Needed to Achieve Self-Sufficiency – Please list and/or mark all the activities you need to complete to achieve self-sufficiency.

- | | | |
|--|--|--|
| <input type="checkbox"/> Complete Job Searches | <input type="checkbox"/> Create a Household Budget | <input type="checkbox"/> Attain a Birth Certificate |
| <input type="checkbox"/> Attend Job Readiness Training | <input type="checkbox"/> Resolve Legal Issues | <input type="checkbox"/> Attain a Driver's License |
| <input type="checkbox"/> Attain a GED or High School Diploma | <input type="checkbox"/> Develop a Resumé | <input type="checkbox"/> Attain a Social Security Card |
| <input type="checkbox"/> Attend an English as a 2 nd Language Class | <input type="checkbox"/> Improve Housing Situation | <input type="checkbox"/> Attain Good Childcare |
| <input type="checkbox"/> Attend Vocational Training Courses | <input type="checkbox"/> Improve Physical or Mental Health | <input type="checkbox"/> Attend Life Skills Training |
| <input type="checkbox"/> Attend College Courses | <input type="checkbox"/> Apply for Other Assistance Programs | <input type="checkbox"/> Attend Parenting Classes |

Other Needed Activities to Achieve Self-Sufficiency (please explain):

Progress Toward Short Term Goal:

Progress Toward Long Term Goal:

Plan Management and Agreements:

_____ I understand that my Welfare Assistance Case Worker will monitor my participation in the activities I have listed in this plan.

_____ I understand this plan will be reviewed and updated on an annual basis for as long as I receive services from this program.

_____ I understand that refusal to participate in this plan may result in the suspension of General Assistance services.

_____ I understand that if any need to be made, I must contact my Tribal Welfare Assistance Case Worker.

_____ Applicant Signature

_____ Date

_____ Tribal Welfare Assistance Case Worker

_____ Date



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Case Plan

Dear Applicant,

The goal of the General Assistance Program is to help you become self-sufficient. The purpose of this plan is to help you determine the steps that are needed for you to become as self-sufficient as possible. Please complete this form if you are **not able to work** and you are excused from work activities due to at least one of the reasons listed on page 6 of the General Assistance Program Application. This plan is required to complete your initial eligibility determination. Please attach additional pages as needed.

Applicant Name: _____ Date: _____

Your Goals – Please list your goals toward self-sufficiency below.

Your Short Term Goals (1 Year):

Your Long Term Goals (5 Years):

Your Strengths – Please list your current abilities, skills, and any work-related experience you may have. This can include experience you have with self-employment through subsistence activities and self-employment through a small business. Please also feel free to list any other strengths you may have. This can include strong connections to family and friends, educational experiences, training, etc.

Strengths:

Your Barriers to Self-Sufficiency – Please list or mark all the circumstances that are making it difficult to achieve self-sufficiency.

- Lack of Adequate Housing
- Limited Childcare
- Limited Education
- Limited English Proficiency
- Physical Health Problems
- Mental Health Problems
- Chemical Dependency
- Other Disabilities

Other Barriers (please explain):



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Steps Needed to Work Toward Self-Sufficiency – Please list and/or mark all the activities you need to complete as you work toward self-sufficiency.

- | | |
|--|--|
| <input type="checkbox"/> Apply for the Adult Temporary Assistance Program (ATAP) | <input type="checkbox"/> Create a Household Budget |
| <input type="checkbox"/> Apply for the Supplemental Nutrition Assistance Program (SNAP) | <input type="checkbox"/> Resolve Legal Issues |
| <input type="checkbox"/> Apply for Vocational Rehabilitation | <input type="checkbox"/> Attain Good Childcare |
| <input type="checkbox"/> Apply for Medicaid or Medicare | <input type="checkbox"/> Attain a Birth Certificate |
| <input type="checkbox"/> Apply for Unemployment Insurance Benefits | <input type="checkbox"/> Attain a Social Security Card |
| <input type="checkbox"/> Apply for the Low-Income Heating Assistance Program (LIHEAP) | <input type="checkbox"/> Attain a Driver's License |
| <input type="checkbox"/> Apply for Supplemental Security Income (SSI) | <input type="checkbox"/> Attain a GED or High School Diploma |
| <input type="checkbox"/> Apply for Social Security Disability Insurance (SSDI) | <input type="checkbox"/> Improve Physical or Mental Health |
| <input type="checkbox"/> Apply for Veterans Benefits (Medical, Educational, Survivors, etc...) | <input type="checkbox"/> Attend Parenting Classes |
| <input type="checkbox"/> Apply for Housing Assistance | <input type="checkbox"/> Attend Job Readiness Training |
| <input type="checkbox"/> Apply for Other Assistance Programs | <input type="checkbox"/> Attend an English as a 2 nd Language Class |

Other Needed Activities to Achieve Self-Sufficiency (please explain):

Progress Toward Short Term Goal:

Progress Toward Long Term Goal:

Plan Management and Agreements:

- _____ I understand that my Welfare Assistance Case Worker will monitor my participation in the activities I have listed in this plan.
- _____ I understand this plan will be reviewed and updated on an annual basis for as long as I receive services from this program.
- _____ I understand that refusal to participate in this plan may result in the suspension of General Assistance services.
- _____ I understand that if any changes need to be made, I must contact my Tribal Welfare Assistance Case Worker.

Applicant Signature

Date

Tribal Welfare Assistance Case Worker

Date



Kawerak, Inc. Education, Employment & Supportive Services Division
Tribal Welfare Assistance Department – 110 East Front Street, Suite 201
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

Health Provider Note

This form must be completed each month by a qualified health provider if you are unable to work due to a health condition.

General Assistance applicant(s): Please bring this form to a qualified health provider. Have the health provider complete the information below verifying you are unable to work due to a health issue. If you need more of these forms, please visit our webpage <https://kawerak.org/supportive-services/welfare-assistance/#>, your local Tribal Office, or contact us at the numbers listed above.

Health Provider: This individual has applied for welfare assistance services and has reported a health condition that may interfere with their ability to work. Please complete the information below for this applicant who is pursuing self-sufficiency.

Patient Name: _____ Date of Birth: _____

Health Provider Name: _____ Phone #: _____

This health note is for the month of: _____ This patient was evaluated on: _____

I am a: Physician Physician's Assistant Health Aide Clinician Chiropractor Nurse Audiologist
 Physical Therapist Occupational Therapist Ophthalmologist Other Health Provider: _____

Do you believe this patient can work full time? No Yes – Please explain: _____

Do you believe this patient can work part time? No Yes – Please explain: _____

The health issues that prevent this patient from working are (check all that apply):
 Permanent Temporary Episodic May Improve Over Time – Please explain: _____

Do you recommend any specific accommodations to help this patient function effectively in a work or training environment if they may one day become employable?

No Yes – Please list accommodations here: _____

Comments – Please attach additional pages as needed: _____

Health Provider's Business/Agency/Company Name: _____

Health Provider Signature _____

Date _____



Kawerak, Inc. Education, Employment & Supportive Services Division

Tribal Welfare Assistance Department – General Assistance Program

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Vendor Payment Request

Dear Applicant - Kawerak pays vendors directly for essential unmet needs. The General Assistance Program cannot pay past due bills or late fees.

Applicant Name: _____ This payment request is for the month of: _____

Pay my **rent** to:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

***Please complete and attach a Landlord Statement.**

Pay my **mortgage** to:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

***Please attach current mortgage bill.**

Pay my **utility bill** to:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

***Please attach current utility bill.**

Pay to **store #1**:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

***Please see the attached purchase list for allowable items.**

Pay to **store #2**:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

***Please see the attached purchase list for allowable items.**

Pay to **other vendor**:

Name: _____

Address: _____

Phone: _____

Amount: \$ _____

***For _____ . Please attach related documents.**

I understand that alcohol, tobacco, and cannabis products, as well as some other products cannot be purchased with General 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

Spouse's Signature (if applicable)

Date



Kawerak, Inc. Education, Employment & Supportive Services Division

Tribal Welfare Assistance Department

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Employment Verification

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

Employer – please complete the following information.

Employee's Job Title: _____

Hourly Wage: \$ _____ Hours Per Week: _____

Date of first paycheck: _____ Date of first full paycheck: _____

Amount of first paycheck: _____ Amount of first full paycheck: _____

This job is: Part Time Full Time On Call Seasonal – Start Date _____ End Date _____

Is the employee listed above still currently employed with you? Yes No - Date of final paycheck: _____

If not, how did this person's employment end? Resigned Job Ended Terminated Other: _____

Comments:

If employment ended, is this person eligible for rehire? Yes No N/A

Supervisor's Name (please print): _____

Supervisor's Job Title: _____ Phone: _____

Employer or Company Name: _____

Mailing Address: _____
P.O. Box or Street City/State Zip

Employer's Signature _____ Date _____



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Work Search Form

This form must be completed each month by General Assistance applicants who are able to work.

General Assistance applicant(s): Please bring this form to employers and apply for jobs. Have the employer complete the information below verifying you have applied for a job. If you need more Work Search Forms, please visit our webpage <https://kawerak.org/supportive-services/welfare-assistance/#>, your local Tribal Office, or contact us at the numbers listed above. If your spouse is applying on the same General Assistance application because they meet tribal enrollment and residency requirements, your spouse must complete this form separately.

Employer or Agency Staff: Please complete the work search information below for this applicant who is pursuing employment.

Applicant Name: _____ This work search is for the month of: _____

Work Search #1 – This section must be completed by an employer or agency staff member.

Date:	Employer or Agency Phone:	Job Title:
Employer or Agency Name:		Employer or Agency Address:

Did you receive a completed application? Yes No Was this applicant interviewed? Yes No N/A
Did you receive a résumé? Yes No N/A Was this applicant offered employment? Yes No N/A

Comments:

Work Search #2 – This section must be completed by an employer or agency staff member.

Date:	Employer or Agency Phone:	Job Title:
Employer or Agency Name:		Employer or Agency Address:

Did you receive a completed application? Yes No Was this applicant interviewed? Yes No N/A
Did you receive a résumé? Yes No N/A Was this applicant offered employment? Yes No N/A

Comments:

Work Search #3 – This section must be completed by an employer or agency staff member.

Date:	Employer or Agency Phone:	Job Title:
Employer or Agency Name:		Employer or Agency Address:

Did you receive a completed application? Yes No Was this applicant interviewed? Yes No N/A
Did you receive a résumé? Yes No N/A Was this applicant offered employment? Yes No N/A

Comments: