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 have 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.
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.
## Important Agency Information

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone</th>
<th>Fax</th>
<th>Website and/or Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Division of Public Assistance</td>
<td>(800) 478-2236</td>
<td>(888) 574-2307</td>
<td><a href="http://dhss.alaska.gov/dpa">http://dhss.alaska.gov/dpa</a></td>
</tr>
<tr>
<td>ATAP, SNAP, GRA, Medicaid, Senior Benefits, APA</td>
<td>(907) 443-2237</td>
<td>(907) 443-2307</td>
<td></td>
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<tr>
<td>Dept. of Labor and Workforce Development</td>
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<tr>
<td>Nome Job Center</td>
<td>(800) 478-2626</td>
<td>(907) 443-2810</td>
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<tr>
<td>State of Alaska Unemployment Office</td>
<td>(800) 252-2557</td>
<td>(907) 465-5573</td>
<td></td>
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<tr>
<td>State Heating Assistance Program</td>
<td>(800) 470-3058</td>
<td>(888) 282-3319</td>
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<tr>
<td>Nome Eskimo Community</td>
<td>(907) 443-2246</td>
<td>(907) 443-9144</td>
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<tr>
<td>Unalakleet IRA Office</td>
<td>(907) 624-3622/ext 30</td>
<td>(907) 624-3621</td>
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<tr>
<td>Cook Inlet Tribal Council (Anchorage Residents)</td>
<td>(877) 98-5900</td>
<td>(907) 700-3422</td>
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<tr>
<td>RuralCap Home Improvements</td>
<td></td>
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<tr>
<td>Weatherization, Senior Access, Modification &amp; Upgrades</td>
<td>(907) 279-2511</td>
<td>(907) 278-2309</td>
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<tr>
<td>Bering Straits Regional Housing Authority</td>
<td>(800) 478-5255</td>
<td>(907) 443-8652</td>
<td><a href="https://www.bsrha.org/">https://www.bsrha.org/</a></td>
</tr>
<tr>
<td>Kawerak Education, Employment &amp; Supportive Services Division</td>
<td>(800) 450-4341</td>
<td>(907) 802-6183</td>
<td><a href="https://kawerak.org">https://kawerak.org</a></td>
</tr>
<tr>
<td>Kawerak Vocational Rehabilitation Program</td>
<td>(877) 759-4362</td>
<td>(907) 443-4362</td>
<td><a href="https://kawerak.org">https://kawerak.org</a></td>
</tr>
<tr>
<td>Kawerak Community Education Department</td>
<td>(907) 443-4463</td>
<td>(907) 802-6183</td>
<td><a href="https://kawerak.org">https://kawerak.org</a></td>
</tr>
<tr>
<td>Kawerak Employment and Training Programs</td>
<td>(907) 443-4371</td>
<td>(907) 802-6183</td>
<td><a href="https://kawerak.org">https://kawerak.org</a></td>
</tr>
</tbody>
</table>

## Applicant(s) Information

| Your Name:                                                                                          |
| (First) (Middle) (Last) (Also Known As or Maiden name)                                               |

Date of Birth: _______ / _______ / _______ Gender: ☐ Male ☐ Female Social Security #: ______________

| Your Spouse’s Name (if applicable):                                                                 |
| (First) (Middle) (Last) (Also Known As or Maiden name)                                              |

Date of Birth: _______ / _______ / _______ Gender: ☐ Male ☐ 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? ☐ No ☐ Yes – Discharge Date: __________ |
| Are you registered with Selective Service? ☐ Yes ☐ No ☐ N/A |
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.

<table>
<thead>
<tr>
<th>Household Type (see above):</th>
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</thead>
<tbody>
<tr>
<td>□ Adult Only</td>
<td>□ One Parent Who is Able to Work</td>
<td>□ Two Parents Where One Parent is Medically Exempt (Not Able to Work)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Full Legal Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Highest Grade Completed</th>
<th>Tribally Enrolled To (if applicable)</th>
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</thead>
<tbody>
<tr>
<td>Self</td>
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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: ______________________________________________ |                                     |
## Tribal Enrollment

I am Tribally enrolled with:

- [ ] Native Village of Brevig Mission
- [ ] Native Village of Elim
- [ ] King Island Native Community
- [ ] Native Village of Savoonga
- [ ] Village of Solomon
- [ ] Native Village of Teller
- [ ] Nome Eskimo Community – Residing in the community of: ______________________________________________________
- [ ] Native Village of Unalakleet – Residing in the community of: ______________________________________________________
- [ ] Other: ___________________________    Residing in the community of: ____________________________________________

*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.

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

<table>
<thead>
<tr>
<th>Current Resources</th>
<th>Applicant</th>
<th>Applicant’s Spouse (if applicable)</th>
<th>Shared Account?</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking Account Balance</td>
<td>$</td>
<td>$</td>
<td>☐ Yes ☐ No</td>
<td></td>
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<tr>
<td>Savings Account Balance</td>
<td>$</td>
<td>$</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Lump Sum Payments (Social Security, VA, Retirement)</td>
<td>$</td>
<td>$</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Other Resources (please specify)</td>
<td>$</td>
<td>$</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Total Current Resources</td>
<td>$</td>
<td>$</td>
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</tbody>
</table>

Monthly Expenses (please list averages)

<table>
<thead>
<tr>
<th>Monthly Expenses (please list averages)</th>
<th>Rent or Mortgage</th>
<th>Childcare</th>
<th>Utilities</th>
<th>Heating Fuel</th>
<th>Basic Necessities (cleaning, hygiene, etc…</th>
<th>Other (please specify)</th>
<th>Total Monthly Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent or Mortgage</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Utilities</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Phone &amp; Internet</td>
<td>$</td>
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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).
### 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#: ____________________________
- [ ] Pending Date: _____________________________  [ ] Denied Date: _____________________________  Total GA Award: $ ____________________________

Comments: ____________________________

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

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<th>Your Short Term Goals (1 Year):</th>
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<th>Your Long Term Goals (5 Years):</th>
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</table>

### 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.

<table>
<thead>
<tr>
<th>□ Limited Job Skills</th>
<th>□ Lack of Adequate Housing</th>
<th>□ Other Barriers (please explain):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Limited Education</td>
<td>□ Limited Childcare</td>
<td></td>
</tr>
<tr>
<td>□ Limited Work History</td>
<td>□ Limited Transportation</td>
<td></td>
</tr>
<tr>
<td>□ Limited Available Jobs</td>
<td>□ Limited English Proficiency</td>
<td></td>
</tr>
<tr>
<td>□ Criminal History</td>
<td>□ Physical Health Problems</td>
<td></td>
</tr>
<tr>
<td>□ No Driver’s License</td>
<td>□ Mental Health Problems</td>
<td></td>
</tr>
<tr>
<td>□ No Birth Certificate</td>
<td>□ Chemical Dependency</td>
<td></td>
</tr>
<tr>
<td>□ No Social Security Card</td>
<td>□ Other Disabilities</td>
<td></td>
</tr>
</tbody>
</table>
# Steps Needed to Achieve Self-Sufficiency

- Complete Job Searches
- Attend Job Readiness Training
- Attain a GED or High School Diploma
- Attend an English as a 2nd Language Class
- Attend Vocational Training Courses
- Attend College Courses
- Create a Household Budget
- Resolve Legal Issues
- Develop a Resumé
- Improve Housing Situation
- Improve Physical or Mental Health
- Apply for Other Assistance Programs
- Attain a Birth Certificate
- Attain a Driver’s License
- Attain a Social Security Card
- Attain Good Childcare
- Attend Life Skills Training
- 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: ___________
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.

**Case Plan**

**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):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### Steps Needed to Work Toward Self-Sufficiency

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

<table>
<thead>
<tr>
<th>Patient Name: __________________________________________</th>
<th>Date of Birth: __________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Provider Name: ________________________________</th>
<th>Phone #: ______________________________</th>
</tr>
</thead>
</table>

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

---

General Assistance Applicants - please fax, email, or drop off this completed form with your application.  

Page 1 of 1
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: ___________________

<table>
<thead>
<tr>
<th>Option</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Pay my rent to:</td>
<td>Name: ____________________________  Address: ____________________________  Phone: __________  Amount: $__________  *Please complete and attach a Landlord Statement.</td>
</tr>
<tr>
<td>☐ Pay my mortgage to:</td>
<td>Name: ____________________________  Address: ____________________________  Phone: __________  Amount: $__________  *Please attach current mortgage bill.</td>
</tr>
<tr>
<td>☐ Pay my utility bill to:</td>
<td>Name: ____________________________  Address: ____________________________  Phone: __________  Amount: $__________  *Please attach current utility bill.</td>
</tr>
<tr>
<td>☐ Pay to store #1:</td>
<td>Name: ____________________________  Address: ____________________________  Phone: __________  Amount: $__________  *Please see the attached purchase list for allowable items.</td>
</tr>
<tr>
<td>☐ Pay to store #2:</td>
<td>Name: ____________________________  Address: ____________________________  Phone: __________  Amount: $__________  *Please see the attached purchase list for allowable items.</td>
</tr>
<tr>
<td>☐ Pay to other vendor:</td>
<td>Name: ____________________________  Address: ____________________________  Phone: __________  Amount: $__________  *For ____________________________  Please attach related documents.</td>
</tr>
</tbody>
</table>

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
# Employment Verification

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>(First)</th>
<th>(Middle)</th>
<th>(Last)</th>
<th>(Also Known As or Maiden name)</th>
</tr>
</thead>
</table>

**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
- [x] 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 __________________________
## 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/#](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.

<table>
<thead>
<tr>
<th>Applicant Name: __________________________________________</th>
<th>This work search is for the month of: __________________</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Date:</th>
<th>Employer or Agency Phone:</th>
<th>Job Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer or Agency Name:</td>
<td>Employer or Agency Address:</td>
<td></td>
</tr>
<tr>
<td>Did you receive a completed application?  □ Yes  □ No</td>
<td>Was this applicant interviewed?  □ Yes  □ No  □ N/A</td>
<td></td>
</tr>
<tr>
<td>Did you receive a résumé?  □ Yes  □ No  □ N/A</td>
<td>Was this applicant offered employment?  □ Yes  □ No  □ N/A</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date:</th>
<th>Employer or Agency Phone:</th>
<th>Job Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer or Agency Name:</td>
<td>Employer or Agency Address:</td>
<td></td>
</tr>
<tr>
<td>Did you receive a completed application?  □ Yes  □ No</td>
<td>Was this applicant interviewed?  □ Yes  □ No  □ N/A</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date:</th>
<th>Employer or Agency Phone:</th>
<th>Job Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer or Agency Name:</td>
<td>Employer or Agency Address:</td>
<td></td>
</tr>
<tr>
<td>Did you receive a completed application?  □ Yes  □ No</td>
<td>Was this applicant interviewed?  □ Yes  □ No  □ N/A</td>
<td></td>
</tr>
<tr>
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<td>Comments:</td>
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</tbody>
</table>

General Assistance Applicants - please fax, email, or drop off this completed form with your application.