"To Elevate the Quality of Life of the People We Serve"

KODIAK AREA NATIVE ASSOCIATION

Employment, Training and Support Services Application

PHYSICAL LOCATION:	194 ALIMAQ DRIVE
MAILING ADDRESS:	3449 REZANOF DRIVE EAST
	KODIAK AK 99615
PHONE:	(907) 486-9879
FAX:	(907) 486-4829
EMAIL:	ETSS@KODIAKHEALTHCARE.ORG

We Offer the Following Beneficiary Assistance Options:

- ☐ Temporary Assistance for Needy Families
- ☐ Job Training/Education
- ☐ Employment/Job Search Assistance
- ☐ Child Care Assistance
- ☐ General Assistance (Akhiok only)
- ☐ Burial Assistance (Akhiok only)

www.kodiakhealthcare.org

Steps To Gaining Assistance:

1. Fill out application.
2. Turn in application with **ALL REQUIRED** documents for processing by Case Manager.
3. Receive approval/denial letter and supplemental documents in mail.
4. Complete supplemental documents.
5. Case Manager will schedule an intake meeting within 10 days after turning in **COMPLETE** application.
6. Bring **ALL REQUIRED** supplemental documents to intake meeting.

REQUIRED Items to Process Application (for **ALL** members of the Household):

- ☐ Certificate of Indian Blood
- ☐ Proof of Tribal Enrollment (if tribally enrolled) for all adults in household (for self-sufficiency plan)
- ☐ Birth Certificate **OR** proof of application for copy of Birth Certificate*****
- ☐ Social Security Card **OR** proof of application for copy of Social Security ******
- ☐ Current Alaska Identification Card or Driver's License (adult household members)
- ☐ Verification of **ALL** household income for the 30 days prior to which you are applying for assistance (or 12 months if seasonal income)
- ☐ Detailed bank statement(s) for past 30
- ☐ Verification of **ALL** other household resources (TANF applicants only)
- ☐ Selective Services registration documentation: All males born after 1960 who have reached their 18th birthday must supply documentation indicating they are registered with Selective Services. If you cannot provide a record, please contact KANA's Community Services.
- ☐ Disclosure of ANCSA dividends form

**If you do not have copies of Birth Certificates for all household members you can print an application online at: https://usvitalrecords.org/alaska/orderbirthcertificate.html*

** *If you do not have copies of Social Security Cards for all household members you can apply for copies online at: http://www.ssa.gov/forms/ss-5.pdf*

Paper copies of both applications are also available at the front desk of KANA Community Services (194 Alimaq Drive).

Applicant Information:

Name:_____ SSN:_____-_____-_____

Permanent Address:_____

Mailing Address: _____

City:_____ State:_____ Zip Code:_____

Phone: (____) _____ - _____ Cell Phone: (_____) _____ - _____

Email Address: _____

Veteran? __Yes __No Discharge Date: _____ Eligible Spouse? __Yes __No

Marital Status: _____Single _____Married _____Divorced ____Widowed ____Separated

Number of Persons in the Household: _____

Current Employment Status: _____Employed __Unemployed _____Not seeking work

Special needs: (Check all that apply)

☐Dental care needs	☐Drug/alcohol problem	☐Family problems
☐Health/medical problems	☐Inadequate Child care	☐Inadequate Housing
☐Lack of appropriate clothing	☐Lack of Food	☐Physical limitations
☐Lack of reliable transportation	☐Pregnancy needs	☐Vision
☐Problems with child or children	☐Disabilities	☐Mental Health

☐Lack of money for daily expenses
☐Trouble with reading or writing
☐Trouble with speaking or understanding English
☐Other: _____

Please explain the circumstances that you checked above:

_____
_____
_____
_____

Are you requesting assistance for anyone in your household who is pregnant? _____Yes_____ No

If yes, who?_____.

Has anyone in your household received public assistance in the State of Alaska or any other state? _____Yes_____ No

Is any adult in your household fleeing from prosecution, custody, or confinement for a felony or a Class A misdemeanor? _____Yes_____ No

Have you or has anyone in your household been convicted of a drug-related felony offense that occurred on or after August 22, 1996? _____Yes_____ No

Are you or is any person in your household on probation or parole? _____Yes_____ No

If yes, please provide probation officer's name:_____

If asked, would you pass a drug screen? _____Yes_____ No

Are you or is any person in your household currently enrolled in any other KANA programs? _____Yes_____ No

If yes, please list:

_____

_____

_____

_____

List All Household Members – PLEASE PRINT

Note: If more space is needed, please attach another piece of paper.

Name	Relationship (not related = "NR")	Birth Date	SSN	Sex: M/F	Race:	Tribal Affiliation
	SELF					

What is the education status of every member of your household?				
Name	Highest Grade Completed	Diploma, Certificate, or Degree (or "NONE")	Date Completed	Location Completed

What are your educational and/or career goals?

What are your spouse's educational and/or career goals?

Monthly Household Expenses

Rent/ Mortgage	$	Water/Sewer	$
Electricity	$	Transportation	$
Oil/Fuel	$	Child Care:	$
Telephone	$	Other:	$
Garbage	$	Other:	$
(For CASE MANAGER USE ONLY) **TOTAL MONTHY EXPENSES:**		**$**	

List all people in your household working and/or self-employed

Person Employed	Relationship to Applicant	Employer	Number of Hours worked	Total Monthly Income
			/ Month	$
			/ Month	$
			/ Month	$
			/ Month	$
			/ Month	$
(For CASE MANAGER USE ONLY) **TOTAL HOUSEHOLD INCOME PER MONTH**			**$**	

Other Monthly Income/Assistance:

Retirement: Armed Forces:	$	Retirement: Other	$
Rental Income	$	Alimony:	$
Insurance Policy Annuities:	$	Survivors Benefits:	$
SSI or Disability	$	Child Support:	$
Public Assistance	$	Aid to the blind:	$
Unemployment Benefits:	$	Work Incentive Program:	$
General Assistance:	$	Food Stamps:	$
ATAP:	$	Pensions:	$
Other:	$	Other:	$
(For CASE MANAGER USE ONLY) **TOTAL HOUSEHOLD INCOME PER MONTH**		**$**	

(For CASE MANAGER USE ONLY) **PAGE TOTAL:** _____

For **TANF** Applicants **ONLY**

List Household Money in Cash or bank/credit union accounts:			
Bank/ Credit Union Name or Cash	Account Number	Account Holder	Amount of/in Cash/Bank/ Credit Union
	#		$
	#		$
	#		$
	#		$
	#		$
List any houses, cabins, property, stocks, bonds, vehicles, boats, and/or other assets owned by anyone in household:			
Owner	Type of Asset	Make/Model/Year (for vehicles)	Value
			$
			$
			$
			$
			$
			$
			$
			$
	(For CASE MANAGER USE ONLY) **TOTAL ASSETS**	**$**	

(For CASE MANAGER USE ONLY) **PAGE TOTAL:** _____

Disclosure of Alaska Native Claims Settlement Act (ANCSA) Dividends

As a Participant in Kodiak Area Native Association's (KANA) Employment, Training and Support Services (ETSS) Programs it is a requirement that you openly and honestly notify your ETSS Case Manager of you and your family's Alaska Native Claims Settlement Act (ANCSA) Dividends.

☐ Yes, someone in my household receives ANCSA Dividends.

Name	ANCSA Corporation	Number of Shares

☐ No, no one in my household receives ANCSA Dividends.

I understand that by signing below I am certifying that the information above is complete and honest. I understand that if I knowingly give false, incorrect, or incomplete information I will be committing fraud/ an intentional program violation.

If fraud or an intentional program violation is suspected/committed an investigation will be conducted. Upon completion of the fraud investigation, and case is deemed an intentional program violation (IPV), the case will close and the following may occur:

- Recoupment of overpayment,
- Court ordered restitution, or
- Criminal prosecution.
-

Name: _____ Date: _____
(Participant Signature)

We often need to contact persons or organizations that can verify your situation to determine your eligibility for temporary or public assistance. When we contact such persons or organizations, we tell them our name, title, and that we work for Kodiak Area Native Association. We are prohibited by law from telling them anything about you or about your temporary or public assistance.

The information we most often need to verify is where you live, who lives with you, and your household's income and resources. We may also ask for information about absent parents for Temporary Assistance for Needy Families applicants.

Please provide the information requested below:

Someone who knows you well:	
Name:	
Mailing Address:	
Phone Number:	
Someone who knows you well:	
Name:	
Mailing Address:	
Phone Number:	
Landlord:	
Name:	
Mailing Address:	
Phone Number:	
Financial Institution (Bank, Credit Union, etc.):	
Name:	
Mailing Address:	
Phone Number:	
Employer:	
Name:	
Mailing Address:	
Phone Number:	

Applicant/Client Appeal Procedure

An applicant who was denied services or feels he/she may have been treated unfairly, has the right to file a written appeal (within 15 days after receipt of a decision) by completing the following procedure:

- **Step 1 – Case Manager**
  An applicant may file a written appeal to the Case Manager to ask for reconsideration of their decision. The Case Manager has ten (10) working days after the date stamped on the appeal to respond. An applicant, who is not satisfied with the Case Manager's decision, may submit their appeal to the Program Manager (Step 2) within five (5) days upon receipt of the Case Manager's decision.

- **Step 2 – Program Manager**
  The Program Manager has ten (10) working days from the date he/she receives an appeal to review documentation, make a decision, and respond. An applicant who is not satisfied with the Program Manager's decision may resubmit their appeal to the Appeal Committee (Step 3) within fifteen (15) days after receiving the Program Manager's decision.

- **Step 3 – Appeal Committee**
  The Appeal Committee will meet to review appeals submitted by applicants. The committee will notify an applicant of their decision within seven (7) working days after the date of their meeting.

All decisions made by the Appeal Committee are final.

Decisions affecting an applicant are made based on a review of program policies, procedures, and the required official documents**. *Reminder: An applicant only has fifteen (15) days after receipt of a decision to register an appeal.***

Certification and Agreement

_____ Initial

I (we) certify to the best of my (our) knowledge that the information and documentation contained in this application is accurate and true. I (we) also understand that additional information may be requested to verify what has been submitted.

_____ Initial

I (we) understand that my (our) application is subject to verification, and that falsification of information shall be grounds for immediate termination from the program and will subject me (us) to federal prosecution under 18 U.S.C. § 1001, which carries a fine of not more than $10,000 or federal imprisonment for not more than five (5) years, or both. I (we) also understand that if I (we) receive services as a result of falsified information, I (we) will have to repay the Tribe for those services.

_____ Initial

I (we) understand and will comply with Goals and Activities outlined in the Self-Sufficiency Plan developed with my (our) Program Case Worker.

_____ Initial

I (we) understand that there is an Appeal Procedure by which I (we) can challenge a decision with regard to this application. I (we) certify that I (we) have received a copy of this Appeal Procedure, have read it, understand it, and will abide by it.

_____ Initial

I understand that I must give 100% effort while participating in the program & that I am responsible for my own success.

_____ _____

Applicant Signature Date

_____ _____

Applicant Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

Authorization for Release of Information

Client Name:_____ DOB:_____

Client Mailing Address:_____

Client Mailing Address:_____

I, _____ authorize the release of information requested by Kodiak Area Native Association's Employment, Training and Support Services (ETSS) Department or its agents. The requested information will only be used in the administration of ETSS Programs, and will not be released to any other person or agency outside of the ETSS Department or its agents. This release of information will be in effect while I am an applicant or recipient of assistance and for any later investigations of my eligibility and receipt of benefits.

Persons that may be contacted include, but are NOT limited to: Tribal, Kodiak Island Housing Authority, Kodiak Women's Resource and Crisis Center, Brother Francis Shelter, Hope Community Resources, Consumer Direct, the Department of Motor Vehicles, the Department of Law, the Department of Public Safety, the Department of Fish and Game, the Department of Labor, the Department of Military and Veteran Affairs, the Department of Revenue, the Bureau of Citizenship and Immigration Services, Office of Family and Children Services, Alaska Housing Finance Corporation, Social Security Administration, Local Governments, Public Assistance Program Contractors and Grantees, Tax Assessors, Financial Institutions, Native Corporations, Stock Brokerage Firms, Landlords, Employers, School Authorities, and Private Individuals.

I understand that I may revoke this authorization in writing at any time by notifying the ETSS Case Manager, except to the extent that action has been taken in accordance with this authorization.

Unless revoked, this authorization will not expire for one year commencing on _____.

Expiration Date: _____

SIGNATURE: I have read this authorization and I understand it:

_____ _____
Signature of Client or Legally Designated Personal Representative Date

_____ _____
Signature of Client or Legally Designated Personal Representative Date

Employer Verification

(if applicable)

I hereby authorize the following person/office to release information concerning my employment status.

_____ _____

Applicant's Signature Date

MUST BE FILLED OUT BY EMPLOYER:

The above named individual has applied for services through the Kodiak Area Native Association's Employment, Training and Support Services Department. Please provide the following information for verification and for payment purposes:

Employer Name: _____

Employer Address: _____

Employer Mailing Address: _____

Phone Number: _____ Fax Number: _____

Employee Name: _____

Date of Hire: _____ Rate of Pay:_____Per:_____

Employee's Schedule:_____

_____ _____

Employer's Signature Date

Landlord Verification

(TANF ONLY)

I hereby authorize the following person/office to release information concerning my housing status.

_____ _____

Applicant's Signature Date

MUST BE FILLED OUT BY LANDLORD:

The above named individual has applied for services through the Kodiak Area Native Association's Employment, Training and Support Services Department. Please provide the following information for verification and for payment purposes:

Landlord Name: _____

Landlord Address: _____

Landlord r Mailing Address: _____

Phone Number: _____ Fax Number: _____

Tenant Name(s) on Lease Agreement: _____

_____

Rental Start Date: _____ Cost of Deposit:_____Monthly Rent:_____

_____ _____

Landlord's Signature Date

How Your Rights Are Protected

The ETSS Case Manager will collect information, including the Social Security Number of each household member who is applying for assistance to determine eligibility for benefits. The Case Manager will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. Case Managers may disclose this information to other Federal and State agencies for official examination, to law enforcement officials for the purpose of apprehending persons seeking to avoid the law, and to private claims collection agencies for claims collection action. Case Managers may verify immigrant status of household members by contacting the US Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits. Providing the requested information, including the Social Security Number (SSN) of each household member for whom you are seeking benefits, is voluntary. However, failure to provide this information will result in the denial of benefits to each individual failing to provide a SSN. Any SSN provided will be used and disclosed in that same manner, regardless of the eligibility of the individual. Case Managers can assist you in applying for a Social Security Number if you are seeking benefits and do not have one. When you sign the application for assistance you consent to release medical records and information about yourself and any other person you are applying for.

(You can get an electronic copy of the Notice of Privacy Practices at http://www.hss.state.ak.us/das/is/hipaa/pdfs/privatehealthcareinfo.pdf. Request a printed copy by writing to the State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, Alaska 99811-0650 or by email at privacyoffical@health.state.us.)

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health & Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, contact USDA or HHA. Write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD). USDA and HHS are equal opportunity providers and employers.

If you have questions about the Americans with Disabilities Act of 1990, contact the Division of Public Assistance Civil Rights Coordinator at (907) 465-3347.