204 Siginaka Way, Suite 300, Sitka, AK 99835 907-747-3207 www.sitkatribe.org

U.S DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS
APPLICATION FOR WELFARE ASSISTANCE

Dear General Assistance Applicant:

To be eligible for General Assistance, you must be Alaska Native or American Indian and enrolled in a Federally Recognized Tribe **or** have a Certificate of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs. You must live within the Sitka Tribe of Alaska service area and submit a completed General Assistance application which includes the following:

- Completed General Assistance Application with **all** questions/sections answered or filled out properly. If a question or section does not apply to you, write "Not Applicable or N/A". **Applications not filled out properly or entirely will not be processed**.
- Proof of Tribal enrollment **or** CDIB for **all** countable household members – an STA caseworker will help you determine who is countable in your household.
- Government- issued photo identification for all countable **adult** household members.
- Proof of residency in Sitka Tribe of Alaska service area – a bill addressed to your address in Sitka is acceptable.
- Proof of **all income** (earned and unearned), which must include bank statement(s) for all countable household members **for the month in which you are applying for assistance.**
- If currently employed, you will need an **Employment Proof** form signed by your employer – STA will let you know if you need this after we review your application.
- If unemployed, provide completed **Work Search/Work Related Activity** Sheets for **each** countable employable adult household member. 12 Work searches per employable adult are required.
- Provide copies of your most recent statements/invoices (bills) and receipts showing payments made for all shelter and utility costs that apply to your household. Shelter and utility bills must be in your name, or the name of your legal husband or wife.
- If there are minor children in your household, you must provide proof that you have applied for ATAP/TANF. If you are not eligible for ATAP/TANF, you must provide proof of denial.
- If applicable, provide proof of legal guardianship of non-biological children in your custody, (i.e. grandchild, niece/nephew, etc.).
- Provide birth certificates for **all** countable minor dependent children in the household – that is, children that are in your legal custody and living in your household.
- Other documentation to determine eligibility or exemption from General Assistance requirements (i.e., medical, disability, social security status, etc.).

Please read the entire application before signing. If you don't understand anything, please contact us before you sign.

A decision will be made within 30 days of your application date, and you will be notified in writing within 45 days of your application date. If you are eligible and employable, you will need to schedule an appointment with the General Assistance Caseworker to develop an Individual Self-Sufficiency Plan (ISP) before payment can be made. If you are eligible and unemployable with a verified medical excuse from work/work activity, you will need to schedule an appointment with the General Assistance Caseworker to develop a case plan before payment can be made.

You will be required to apply for other federal, state, and Tribal financial assistance programs for which you are eligible. However, please note that if you are **already** receiving ATAP/TANF, Adult Public Assistance, Disability, or any other State, Federal or Tribal financial assistance, you may be determined ineligible for General Assistance under the federal regulations.

If you have any questions or concerns regarding the General Assistance application process, please call the General Assistance Caseworker at 907-747-7245. We are here to help you!

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APPLICATION FOR WELFARE ASSISTANCE

Incomplete applications will not be processed. Please call 907-747-7245 for help.

Name of Applicant: Last 4 #s of Social Security #:

Maiden Name or
Other Names Used: Date of Birth:

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

Physical Address: Street Address City State Zip

Home Phone#: Message Phone#: Work Phone#:

Marital Status: Single Married Separated Divorced Widowed

List all members of the household. Enter an asterisk (*) in the column at left of the name for each person **not included** in the General Assistance application budget. Please ask us for help with this!

*	Name	Relationship to head of household	Date of birth	Last 4 numbers of SSN	Tribal Enrollment#	Monthly income

Members of household with physical, mental or behavioral disability				
Name	Nature of disability	Temporary or Permanent?	Major or minor?	STAFF USE ONLY

How many persons live in the household? _____ Adults _____Children

Where do you live now? Own Home Rent House/Apartment Rent Room

With Relatives With Friend(s) Other:_____

Are you or any member of your household a shareholder in a Native Corporation? Yes No

If yes, list the name of household member and Corporation(s) here: (use back side of form if necessary)

Members of household with shares in a Native Corporation		
Name of household member	Name of Native Corporation	# of shares

Have you received ATAP or TANF in the last month? Yes No

If yes, how much: $_____

Has your ATAP/TANF been reduced due to penalties? Yes No

If yes, why:_____

Have you been terminated from ATAP/TANF? Yes No

If yes, date of termination: _____

Have you been determined ineligible for ATAP/TANF? Yes No

If yes, why?_____

Have you been denied ATAP/TANF? Yes No

If yes, why?_____

Are you eligible to reapply for ATAP/TANF? Yes No

If yes, date you are eligible to reapply:_____

What TANF office did you receive assistance from? _____

EXPLAIN FULLY how you have supported yourself during the past three (3) months AND what has changed in your situation to cause you to apply for assistance. Failure to complete this section will render this application incomplete, and therefore, it will not be processed.

Do you have an Individual Indian Money (IIM) account? Yes No

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RECORD OF INCOME AND RESOURCES

Does anyone in your household have income from any source? Yes No

If yes, list the name of household member(s), source of income and amounts below

You are required to report all monthly income from any of the sources listed below

Source of Income/Resources	Amount	Name of Household Member
Salary #1: Applicant's Income/Salary	$	
Salary #2: Spouse's Income/Salary	$	
Tips or Gratuities	$	
ATAP –TANF-ASAP (State assistance)	$	
Child Support and Alimony	$	
Foster Care Payments	$	
Adult Public Assistance (APA)	$	
Social Security (SSA RETIREMENT)	$	
Supplemental Security Income (SSI)	$	
Disability Insurance (SSDI or private ins.)	$	
Alaska State Permanent Fund (PFD)	$	
Cashouts of Retirement or Pension Plans	$	
State Longevity	$	
Veteran's Benefit	$	
Unemployment Insurance Benefits	$	
Worker's Compensation	$	
Food Stamps	$	
Medicare/Medicaid	$	
Native Corporation Dividends	$	
Checking Account (provide statement showing balance)	$	
Savings Account (provide statement showing balance)	$	
Student Loans/Grants/Scholarships	$	
Bingo or Pull Tab Winnings	$	
Other Income	$	
Total Monthly Income for household	$	

Monthly Shelter Costs
Please list all expenses for the current month

Rent	$	Telephone	$
Space Rent	$	Water	$
Mortgage Payment	$	Sewer	$

Electricity	$	Household Oil/Fuel/Wood	$
Heating	$	Other	$

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Fraud/Information Privacy Statement

I/We apply for financial assistance/services for the listed members of my/our household who are in need.

I/We have received a copy of and have had explained to us and understand the provisions of federal law governing fraud.

Applicants or recipients who knowingly and willfully provide false or fraudulent information are subject to prosecution under 18 U.S.C. §1001, the federal law concerning fraud, which carries a fine of not more than $10,000 or imprisonment of not more than five years or both.
Initials of applicant(s)_____

I/We agree to supply information regarding resources and income and to notify the agency of any changes in my (our) situation. Release of Information: Human Services is authorized to obtain/exchange information necessary to establish eligibility for assistance. I/We have read, or had explained to me/us, the provision of our protection under the Paperwork Reduction Act and the Privacy Act.

Initials of applicant_____

_____	_____	_____
Signature of applicant	Printed name of applicant	Date

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Information Release Form

I, , hereby authorize the release of information requested by the Sitka Tribe of Alaska 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 Program or its agents except as required to verify eligibility and as required by law. I hereby authorize the Sitka Tribe of Alaska to obtain and exchange information related to my applications to participate in their programs. And, to arrange for such participations based on my employability assessment and plan for employment related activities. **This release of information shall be in effect while I am an applicant or recipient of General Assistance, and for any later inquiries pertaining to my eligibility and receipt of General Assistance benefits**.

Persons or organizations that may be contacted include, but are not limited to: the Department of Labor, the Department of Military Affairs, Alaska State Housing Authority, Regional Housing Authorities, Social Security Administration, local and tribal governments, State of Alaska ATAP, Tribal TANF or other public assistance program contractors and grantees, health care providers, tax assessors, banks and credit unions, Native corporations, landlords (including family/friends who are renting to applicant), employers, school authorities, and all departments and programs administered by the Sitka Tribe of Alaska.

FRAUD NOTICE: Under 18 U.S.C. §1001, the Federal Law concerning fraud states: "Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or devise a material fact, 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 or imprisoned not more than five years or both."

A reproduction or copy of this release is as valid as an original

_____ _____
Applicant Signature Signature of Witness if signed with an "X"

_____ _____
Printed Name of Applicant Printed Name of Witness if signed with an "X"

_____ _____
Last four numbers of Social Security Number Date of Witness Signature _____

_____ Date of Applicant Signature _____

Work Search/Work Related Activity Form

Applicant: Please provide copies of this form for each adult member of your household who is currently unemployed.

Employer: Please complete the information below for the applicant who is pursuing employment with your organization or business.

Name of Applicant: _____

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This section to be completed by Employer

Job Title/Work Activity:				
Employer/Business name:		Employer Phone:		
Employer address:				
Did applicant submit a complete application?	Yes	No		
Did applicant submit a resume?	Yes	No		
Was applicant interviewed for the job?	Yes	No		
Was applicant offered employment?		Yes	No	
Did applicant accept employment?		Yes	No	
Did applicant refuse employment?		Yes	No	
Comments: Employer/Supervisor Name:		Employer/Supervisor Signature:		
Date:				

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Social Services Program Appeal Procedure

An applicant who is denied services or benefits, or a client who has their services or benefits terminated or reduced has the right to appeal the denial, reduction, or termination of benefits by following this procedure. Failure to follow the procedure shall be sufficient grounds for an appeal to be denied.

Appeal to Department Director

An applicant or client has thirty (30) days from the date of receipt of a written decision by Social Services program staff to submit an appeal to the Social Services Department Director. The appeal must be in writing to the Department Director, delivered by electronic mail, US mail, or in person by hand. Any decision not appealed within 30 days shall be final.

Upon receipt of an appeal, the Social Services Department Director may designate another qualified STA employee with no involvement in the original decision to address the appeal if he/she/they is unavailable or has a conflict of interest.

The Department Director or his/her/their designee shall schedule a hearing with the client to review the decision within ten (10) business days of receipt of the written appeal. The applicant shall be provided with a written notice of the hearing, which shall include:

- the date, time and location of the hearing, which may be held in person or virtually by videoconference unless the applicant/client objects to a virtual hearing;
- statement of the facts and issues giving rise to the appeal;
- statement that the applicant has the right to give oral and/or written evidence during the appeal and to confront and cross-examine any witnesses at the hearing;
- notice that the applicant or client has a right to one continuance, of not more than 10 days, with respect to the date of the hearing;
- notice that the applicant or client may, in reasonable time before the hearing, copy or examine all information in their file related to the proposed action being contested.

Failure of the applicant or client to respond to the notice of hearing, or failure to appear at the hearing or request a continuance, shall be sufficient grounds to deny the appeal.

The hearing shall be informal, orderly, and recorded. The applicant or client may have an advocate or legal representative in attendance at the hearing at their own expense. A copy of the transcript of the hearing will be provided to the applicant or recipient upon request within five (5) business days.

The Department Director or his/her their designee shall review information presented at the hearing, the program regulations, policies, procedures, and information in the applicant or client's file in considering the appeal. The Department Director or his/her/their designee shall make a decision on the appeal within ten (10) business days following the hearing, or within ten (10) business days after the client has not responded to a request to schedule a meeting or failed to appear for a scheduled hearing. The decision shall be in writing, shall state the evidence considered and the reasons for the decision, and shall be delivered to the applicant in person, by certified mail with return receipt, or by electronic mail.

Appeal to the Chief Executive Officer

An applicant or client has ten (10) business days from the date of receipt of a decision by the Social Services Department Director or his/her/their designee to appeal to the Tribe's Chief Executive Officer. Grounds of appeal shall be limited to the following:

- Failure by the Social Services Department Director or his/her/their designee to follow the Appeals Procedure.
- Conflict of Interest or other violation of STA Code of Conduct on the part of the Social Services Department Director or his/her/their designee related to the decision.

The appeal must be in writing to the Chief Executive Officer, delivered by electronic mail, US mail, or in person by hand. The Chief Executive Officer may designate another qualified STA employee with no prior involvement in the case to address the appeal if he/she/they is unavailable or has a conflict of interest.

The Chief Executive Officer or his/her/their designee shall review the decision issued by the Social Services Department Director or his/her/their designee and all documentation related to the decision in the applicant or client's file, including the transcript of the hearing, and shall make a decision within ten (10) business days of receipt of the appeal. The decision of the Chief Executive Officer or his/her/their designee shall be final and not subject to further appeal.