NATIVE VILLAGE OF KOTZEBUE
KOTZEBUE IRA

Native Village of Kotzebue
P.O. Box 296 Kotzebue, Alaska 99752
907-442-5317 Fax 907-442-4013

APPLICATION FOR GENERAL ASSISTANCE

******INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED******

Name: **SS#:**

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 box at left of the name for each person NOT INCLUDED in General Assistance application budget.

*	NAME	RELATION TO HEAD	DATE OF BIRTH	SEX	SOCIAL SECURITY #	TRIBE ENROLL #	MONTHLY INCOME

MEMBERS OF HOUSEHOLD WITH PHYSICAL OR MENTAL HANDICAP

NAME	NATURE OF PROBLEM	TEMPORARY or PERMANENT	MINOR or MAJOR	VERIFIED

How many persons live in the house: _____ **Adults** _____**Children**

Type of Service Applying for: ☐General Assistance ☐Emergency

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 backside of form if necessary)

MEMBERS OF HOUSEHOLD WHO OWN SHARES IN A NATIVE CORPORATION		
NAME	NATIVE CORPORATION	# SHARES OWNED

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 **Reason:_____**

Have you been terminated from ATAP/TANF: ☐Yes ☐No **Date of termination:___/___/___**

Have you been determined ineligible for ATAP/TANF: ☐Yes ☐No **Reason:_____**

Have you been denied ATAP/TANF: ☐Yes ☐No **Reason:_____**

Are you eligible to reapply for ATAP/TANF: ☐Yes ☐No **Date able to reapply:___/___/___**

What TANF office did you receive assistance from: **Please list:_____**

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. Please include all other information you feel would help us better assist you.

_____

_____

_____

_____

_____

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 INCOME RECEIVED FROM THE FOLLOWING******

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)	**$**	
Social Security (SSA)	**$**	
Supplemental Security Income (SSI)	**$**	
Disability Insurance	**$**	
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	**$**	
Savings Account	**$**	
Student Loans/Grants/Scholarships	**$**	
Bingo or Pull Tab Winnings	**$**	
Other Income	**$**	
Other Income	**$**	
TOTAL MONTHLY INCOME	**$**	

MONTHLY SHELTER COSTS

******PROVIDE ALL EXPENSES FOR THE CURRENT MONTH******

Rent	**$**	**Telephone**	**$**
Space Rent	**$**	**Water**	**$**
Mortgage Payment	**$**	**Sewer**	**$**
Electricity	**$**	**Household Oil/Fuel/Wood**	**$**
Heating	**$**	**Other**	**$**

READ BEFORE SIGNING

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

_____ _____

Applicant Signature **Signature of Other Adult Household Member**

_____ _____

Printed Name **Printed Name**

_____ _____

Date **Date**

************FOR OFFICE USE ONLY************

Date Application Received:_____ **Application Received By:**_____

DECISION OF APPLICATION: ☐ **Approved** ☐ **Denied** **Date:**___/___/___

(Review Dates: ___/___/___ ___/___/___ ___/___/___**)**

1-Month Review **3-Month Review** **6-month Review**

COMMENTS/NOTES:_____

_____

_____

_____

_____

Caseworker Signature: _____ **Date:** _____