***Native Village of Kotzebue/Kotzebue IRA***
Food Distribution Program
*PO Box 296*
*City, Alaska 99559*
PHONE: (907) 442-3467 FAX: (907) 442-2162

HEAD OF HOUSEHOLD SOCIAL SECURITY NUMBER: _____

HAVE YOU APPLIED FOR FOOD STAMPS YES OR NO
DO YOU RECEIVE FOOD STAMPS NOW YES OR NO

HOW MANY PEOPLE IN YOUR HOUSEHOLD _____

## APPLICATION FOR FOOD DISTRIBUTION

ANSWER THE FOLLOWING QUESTIONS HONESTLY AND COMPLETELY. IF YOU KNOW BUT REFUSE TO ANSWER OR GIVE NEEDED INFORMATION, YOUR HOUSEHOLD (MEMBERS WHO PREPARE AND PURCHASE MEALS TOGETHER) WILL NOT BE ELIGIBLE FOR FOOD DISTRIBUTION BENEFITS.

APPLICATIONS CAN BE FILED BY THE APPLICANT OR AN AUTHORIZED REPRESENTATIVE AT THE TRIBAL OFFICE, BY MAIL, OR BY FAX MACHINE.

**IMPORTANT:** WHEN YOUR HOUSEHOLD IS INTERVIEWED, PLEASE BRING PROOF OF ALL HOUSEHOLD INCOME. FOR EXAMPLE: PAY STUBS, A COPY OF ALL PAYSTUBS OR COPIES OF AWARD LETTERS FROM SOCIAL SECURITY BENEFITS, SUPPLEMENTAL SECURITY INCOME, GA, PA, AND TANF. COMPLETED APPLICATIONS WILL SPEED UP THE REVIEW OF YOUR APPLICATION.

HEAD OF HOUSEHOLD: _____

MAILING ADDRESS: _____ AK _____
STREET CITY STATE: ZIP

_____ AK _____
PO BOX # CITY STATE ZIP

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: _____

HOUSEHOLD LOCATION: _____

HOUSEHOLD RACIAL-ETHNIC HERITAGE:
ALTHOUGH, YOU ARE NOT REQUIRED TO PROVIDE THIS INFORMATION, YOUR COOPERATION WILL HELP DETERMINE COMPLIANCE WITH THE FEDERAL CIVIL RIGHTS LAW. IN NO INSTANCE WILL THIS INFORMATION BE USED IN CONSIDERING YOUR ELIGIBILITY FOR ASSISTANCE. IF YOU DECLINE TO PROVIDE THIS INFORMATION IT WILL IN NO WAY AFFECT CONSIDERATION OF YOUR APPLICATION. WE ARE AUTHORIZED TO ASK FOR THIS INFORMATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.

BLACK/AFRICAN AMERICAN: _____
HISPANIC or LATINO: _____
ASIAN OR PACIFIC ISLANDER: _____
AMERICAN INDIAN OR ALASKAN NATIVE: _____
WHITE - NOT OF HISPANIC ORIGIN: _____

**FOR OFFICE USE ONLY:**

**CASE NUMBER:** _____
**DATE RECEIVED:** _____

ARE YOU OR ANYONE IN YOUR HOUSEHOLD ENROLLED WITH THE BUREAU OF INDIAN AFFIAIRS (BIA) OR AN ALASKA NATIVE REGIONAL CORPORATION OF THE ALASKA NATIVE CLAIMS SETTLEMENT ACT (ANCSA)?

BIA or ANCSA ENROLLMENT NUMBER: _____

_____ (YES OR NO) ANCSA CORPORATION NAME: _____

DO YOU RESIDE WITHIN THE VILLAGE BOUNDARY? _____ (YES OR NO) COPY UTILITY/PHONE BILL: _____ (YES OR NO)

FILL IN ALL BLANKS FOR EACH HOUSEHOLD MEMBER, INCLUDING YOURSELF. PEOPLE WHO LIVE AND EAT WITH YOU SHOULD BE LISTED AS HOUSEHOLD MEMBERS. (Do not list roomers and boarders)

ALTHOUGH YOU ARE NOT REQUIRED TO DO SO, WE WOULD LIKE YOU TO INCLUDE THE SOCIAL SECURITY NUMBER OF EACH MEMBER OF YOUR HOUSE-HOLD WHO HAS ONE. THIS WILL HELP US TO IDENTIFY YOUR HOUSEHOLD CORRECTLY. THESE SOCIAL SECURITY NUMBERS MAY ALSO BE USED IN PROGRAM REVIEWS OR AUDITS TO MAKE SURE YOUR HOUSEHOLD IS ELIGIBLE FOR FOOD DISTRIBUTION BENEFITS. WE ARE AUTHORIZED TO ASK FOR THIS INFORMATION UNDER THE TAX REFORM ACT OF 1976.

| | NAME (First, Middle, Last) | DATE OF BIRTH | SOCIAL SECURITY # | RELATIONSHIP |
|---|---|---|---|---|
| 1. | | | | SELF |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10 | | | | |
| 11 | | | | |

***{TRIBAL AGENCY NAME}* OFFICIAL USE ONLY**

HOUSEHOLD LOCATED ON OR NEAR VILLAGE BOUNDARY? YES OR NO

HOW WAS LOCATION VERIFIED? _____

**FOR ANTHC FDPIR OFFICE USE ONLY**

EIS CHECKED FOR THIS APPLICANT'S SNAP/FOOD STAMP STATUS YES OR NO

WHO CHECKED (INITIAL): _____ DATE: _____

SOA Case #'s: _____ Case # 2: _____

## RESOURCE TEST NO LONGER REQUIRED

As of **September 26, 2013**, the resource test is no longer a requirement. However, bank statements may contain direct deposits of unearned income information (e.g., SS, SSI, SSD, UI, GA, etc.) and may be used to help verify income.

## UTILITY/SHELTER, EXPANDED MEDICAL & HOME CARE DEDUCTION(S)

| | | |
|---|---|---|
| RENT/MORTAGE RECEIPT? | YES OR NO | STANDARD SHELTER/UTILITY DEDUCTION BASELINE FOR WESTERN REGION (AK, AZ, CA, ID, NV, OR, WA) - $350 |
| HEAT/ELECTRIC RECEIPT? | YES OR NO | |
| PHONE RECEIPT? | YES OR NO | **IF YES, ADD BASELINE DEDUCTION:** |

Are you a senior 60 years of age or older? Do you pay out of pocket medical expenses in excess of $35 a month, not covered b Indian Health Service? YES OR NO **IF YES, TOTAL AMOUNT:**

Do you have or pay for a personal care attendant (PCA)? YES OR NO **IF YES, TOTAL AMOUNT:**

Do you pay Medicare Part B, Part D, or both premiums? YES OR NO **IF YES, TOTAL AMOUNT:**

Answering **"YES"** to any medical question above requires documented verification (e.g., award letters or receipts).

## INCOME

**1. EARNED INCOME** SELF EMPLOYED - Is anyone in your household self-employed? YES OR NO

If yes, please ask for and complete the Self-Employment Income form (FDP004) and bring in the Federal Income Tax forms filed by all self-employed members in your household. If no such tax forms were filed last year, bring proof of all self-employment income and expenses.

Total **gross** self-employment income: _____

Total **gross** business expenses: _____

**2. WAGES AND SALARIES**: Is anyone in your household employed?

Fill in all blanks for each member with a full or part-time job. If a member has more than one job, list each job separately. Include members who receive income from the Comprehensive Employment & Training Act (CETA). Do not include self-employed household members. Please indicate whether the job is 1. Full Time Permanent-FTP., 2. Full Time Temporary-FTT. **3. Part Time Permanent-PTP., 4. Part Time Temporary-PTT.**
If it's a Temporary Job, when will the job end? Date: _____

| HOUSEHOLD MEMBER | EMPLOYER | HOW OFTEN PAID: WEEKLY WAGES | Bi-Weekly WAGES | Twice/month WAGES | MONTHLY WAGES | FTP FTT PTP PTT |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | TOTALS: | $ - | $ - | $ - | $ - | |

**3. EDUCATIONAL GRANTS, SCHOLARSHIPS**

**Gross** monthly income from educational grants, scholarships: $ -

Enter monthly tuition and mandatory fees: $ -

## UNEARNED INCOME

| Income Source | Who Receives | Monthly | HOW OFTEN RECEIVED: Twice Month | Bi-weekly | Weekly |
|---|---|---|---|---|---|
| **Social Security Benefits** | | | | | |
| **SSI (Supplemental Security Income)** | | | | | |
| **Pensions or Retirement Income** | | | | | |
| **VA (Veterans Benefits)** | | | | | |
| **Unemployment Insurance** | | | | | |
| **GA (General Assistance)** | | | | | |
| **PA (Public Assistance)** | | | | | |
| **TANF (Temporary Assistance to Needy Families)** | | | | | |
| **Child Support or Alimony** | | | | | |
| **Other (specify)** | | | | | |
| | TOTALS: | $ - | $ - | $ - | $ - |

**ATTENTION: Please indicate if anyone in your household is disabled**

NAME

**DEDUCTIONS:** Care for child or other dependents - must be provided by someone outside of the household and necessary for a household member to search for, accept, or continue employment or continue employment or to attend training and pursue education that is preparatory to employment.

1. Dependent Care Costs

| Dependent's Name | Provider | Date of Birth | Monthly Cost |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

2. Legally required child support paid to a non-household member:
(Legal obligation and actual payment must be verified)

TOTAL DEDUCTIONS: $ -

FDP001

**RULES OF UNDERSTANDING: By my initials below I understand and agree to the following eight (8) rules:**

1) To **report any changes** in residence within 10 days.
2) To **report any changes** to my household size within 10 days.
3) To **report any changes** in my shelter/utility expenses within 10 days.
4) To **report any changes** or increase in gross monthly income over $100 within 10 days.
5) To **report any changes** in a household member's obligation to pay child support within 10 days.
6) It **is prohibited** to receive both SNAP (food stamps) or FDPIR benefits within the same month.
7) It **is prohibited** to give any false or misleading information to receive food distribution benefits.
8) It **is prohibited** to barter/trade or sell my household's food distribution benefits. **Initials:** _____

**INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES:** If you or a household member knowingly/willingly violate the rules initialized above, it is considered an Intentional Program Violation (IPV). Households who have been found guilty of committing an IPV will be ineligible to participate in both FDPIR and SNAP programs for a period of twelve (12) months for the first violation, 24-months for the second violation and permanently for the third violation; even prosecuted by authorities.

**Initials:** _____

**FAIR HEARING:** If you disagree with any action taken on your case, you and/or your representative have the right to request a fair hearing. You may request a fair hearing verbally or in writing. If you request a fair hearing, your case may be presented by a member of your household or representative, such as a legal counsel, a relative, a friend or other spokesperson.

**Initials:** _____

**NON-DISCRIMINATION STATEMENT**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1) Mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;
2) Fax: (202) 690-7442; or
3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider. **Initials:** _____

**AUTHORIZATION:** I authorize the release of any necessary information or forms to ANTHC's Food Distribution Office and *{TRIBAL AGENCY NAME HERE}* , from individuals, businesses, schools, banking institutions, Federal/State/Tribal agencies needed to verify my eligibility for the Food Distribution Program. I understand that this information will be kept confidential and used only for the purpose of helping to document my eligibility for the Food Distribution Program. This authorization is good for the entire period for which I am deemed certified and eligible to receive food distribution benefits, which could last up to 24 months or until revoked by me in writing.

**OPTIONAL (Parents w/Children):** By my initials below I authorize the ANTHC Food Distribution Office the permission to share my household information with the State of Alaska, Division of Child & Early Development, Child Nutrition Programs, for the sole purpose of automatically enrolling my child(ren) to participate in and receive free school meals for as long as I am certified for food distribution beneifts.

| INITIAL YES: | INITIAL NO: |
|---|---|

**CERTIFICATION STATEMENT:** I certify that I have read this application and that the information contained in it is true and correct to the best of my knowledge. I understand that I must comply with program rules and provide additional documentation if required, and that any false or misleading information on this form may be grounds for disqualification and/or claim action. By my initials above I have acknowledged complete understanding of my rights and responsibilities to participate and receive food distribution benefits, and that I am responsible for reporting any changes in my household's size, changes income over $100 and/or changes to my contact information to the Food Distrbution Program Tribal Agency Office, within 10 days of the date the changes become effective.

_____ _____

**Applicant or Authorized Representative Signature** **Date**

_____ _____

**Tribal Agency Representative Signature** **Date**

**AUTHORIZED REPRESENTATIVE(S):** Person(s) identified outside my household are authorized to pick up my food package

**#1 - Name:** _____

#1 - Address: _____

#1 - Phone(s): _____

**#2 - Name:** _____

#2 - Address: _____

#2 - Phone(s): _____

**#3 - Name:** _____

#3 - Address: _____

#3 - Phone(s): _____