

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

Na	ame:			SS	#:				
	niden Name or her Names Used:			Da	te of Birt	h: /	1		
				Da	te of Birt	· /	1		
M	ailing Address: P.O. Box or	Street Address	eet Address City			Stat	e	Zip	
Ph	ysical Address:								
	Street Addre	ess		City		Stat	e	Zip	
Home Phone#:		Messaş	Message Phone#: Wo			rk Phone#:			
M	arital Status:	de Mai	rried 🗌	Separate	ed 🔲 I	Divorced]Widowed		
	List ALL MEMBERS of t	he Household. E <u>INCLUDED</u> i					ne for each pers	on <u>NOT</u>	
*	NAME	RELATION TO HEAD	DATE OF BIRTH	SEX	SOCIAI	L SECURITY #	TRIBE ENROLL#	MONTHLY INCOME	
MEMBERS OF HOUSEHOLD WITH PHYSICA NAME			LL OR MENTAL HANDICAP NATURE OF PROBLEM			TEMPORARY or PERMANENT	MINOR or MAJOR	VERIFIED	
Н	ow many persons live in the ho	ouse:	Adults		Chi	ldren			
	Type of Service Applying for: General Assistance Emergency								
W	here do you live now? Own	n Home Ren	t House/Apai	tment		Rent Room	☐With Relatives		
─With Friend(s)					Other:				
Aı	Are you or any member of your household a shareholder in a Native Corporation?								

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

	NATIVE CORP	ORATION	# SHARES OWNED	
ave you received ATAP or TANF in the last month:	□Yes	□No	If yes, how much: \$	
as your ATAP/TANF been reduced due to penalties:	□Yes □Yes □Yes	□No	Reason:/ Date of termination:/ Reason: Reason:	
lave you been terminated from ATAP/TANF:		□No		
lave you been determined ineligible for ATAP/TANF:		□No		
lave you been denied ATAP/TANF:		□No		
re you eligible to reapply for ATAP/TANF:	□ Yes	□No	Date able to reapply:/_	
Vhat TANF office did you receive assistance from:	Please list:_			
XPLAIN <i>FULLY</i> , how you have supported yourself during t				
	nformation you fee	el would hel	p us better assist you.	
o cause you to apply for assistance. Please include all other in			p us better assist you.	
RECORD OF INCO Oces anyone in your household have income from any source? If yes, list the name of household memb	ME AND RESC	OURCES ('es	□No	

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 Ad	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: / / I-Month Review	/ / 3-Month Review	6-month Review		
COMMENTS/NOTES:				
Caseworker Signature:	Di	ate:		