



KODIAK AREA NATIVE ASSOCIATION

# TRIBAL TANF PROGRAM MONTHLY ELIGIBILITY REPORT

<b>Include copies of all monthly bills:</b> -- Rent -- Electric -- Phone -- Oil --	<b>This report is for the month of:</b> _____	<b>Name:</b> _____
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**Complete, sign and return this report by the 10<sup>th</sup> of the month.**

- You must report within **5 DAYS** changes that may affect your eligibility.
- Answer all questions for everyone in your TANF case.
- Information reported may result in your benefits being increased, decreased, or stopped.

**1. Did anyone receive (earned) money from a job or training program?      YES      NO**  
 If "YES" complete below. Please list gross amounts (amount before taxes). If self-employed: attach proof of income. If you claim actual expenses, list expenses on a separate sheet of paper.

<u>Who received income:</u>	<u>Employer:</u>	<u>Date received:</u>	<u>Gross amount received:</u>

**2. Did anyone receive (unearned) money from any other source?      YES      NO**  
 If "YES" complete below. Please include child/spousal support, Corporation Dividends, Insurance or Legal settlements, Cash gifts, Loans, Scholarships, Tax Returns, and/or Unemployment.

<u>Who received income:</u>	<u>Source:</u>	<u>Date received:</u>	<u>Amount received:</u>

**Please provide proof of all income (earned and unearned) with pay stubs or bank statements.**

**3. Did anyone receive assistance through another program?      YES      NO**  
 If "YES" complete below. Please include Food Stamps, Sun'aq Tribe of Kodiak, Brother Francis Shelter, and other programs and/or agencies that offer financial assistance. Please attach proof of this assistance if not Food Stamps.

<u>Who received income:</u>	<u>Source:</u>	<u>Date received:</u>	<u>Amount received:</u>
	Food Stamps		

**4. Is any household member avoiding or running for the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole?      YES      NO**  
**5. Has any household member been convicted of a drug related felony for possession, use, or distribution of a controlled substance(s)?      YES      NO**

<u>Who:</u>	<u>Conviction/Charge:</u>	<u>Date of charge/conviction:</u>

**6. Has there been a significant change in your household? YES NO**

If "YES", complete below. Please include: births, temporary absences (school, treatment, etc.), start or end of a job, new household member, etc. *PLEASE INCLUDE EXPECTED CHANGES*

**Types of Changes to report:**

- **Income:** Starts, changes or stops
- **Job/Training:** Starts, stops, quits or refuse of job or training, change in hours
- **Babies:** If you become pregnant, have a baby, abort or miscarry
- **Household:** Someone moves in or out, Marriage, divorce, or separation
- **Checking/Savings:** Open or close a checking or savings account
- **Property:** Buy, sell, trade, or give away, or get a vehicle, home, land, etc.
- **Disability:** Become disabled or recover from disability
- **ANY CRIMINAL CONVICTONS/ARRESTS!**

<u>Who changed:</u>	<u>Change that occurred:</u>	<u>Date of change:</u>

**Did you move, get a new mailing address, or change your number?**

<b>New Home Address:</b> _____	<b>New Phone Number:</b> _____
<b>New Mailing Address:</b> _____	<b>Date Moved/Reason For Move:</b> _____

**CERTIFICATION**

**I UNDERSTAND THAT:**

- I must *contact my caseworker within 5 days of any changes* in my household that may affect my eligibility of the amount of cash aid.
- Facts I report may result in an increase, decrease, or termination of assistance. If I knowingly give false facts or do not report changes in order to continue receiving assistance or benefits my assistance or benefits will be terminated.
- Payments may be delayed or terminated because of *late or incomplete Monthly Eligibility Reports*.
- If on purpose I do not report all facts or give false information about my income, property, or family status or get to keep getting aid or benefits, I can be legally prosecuted. And I may be charged with committing a felony if more than \$400.00 in cash aid is wrongly paid out. I understand that the penalties for welfare fraud can be up to \$10,000 dollars and/or three years in prison. Conviction or proof of welfare fraud can also result in the discontinuation of future aid from the Alaska Tribal TANF Partnership.

**Participant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**THIS FORM MUST BE SIGNED & DATED IN ORDER TO BE COMPLETE**

I declare under penalty of perjury under the laws of the United States and the State of Alaska that the facts contained in this report are true and correct and complete for the entire report month.

**Participant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions:** Record your daily activities on this form. Please note that a ***minimum of 20 hours per week*** is required to receive cash assistance. Non-participation may result in a cash reduction/sanction. Activities listed should relate to the goals outlined on your Self-Sufficiency Plan. If you have questions about completing this form, contact your Case Manager.

<b>Participant Name:</b>			<b>Reporting Month:</b>			
<b>Code</b>	<b>Activity</b>	<b>Week 1</b>	<b>Week 2</b>	<b>Week 3</b>	<b>Week 4</b>	<b>Week 5</b>
1	Paid Employment					
2	Self-Employment					
6	Work Experience					
8	Work Search					
12	Community Service					
16	Vocational Training					
18	College					
20	Job Skills Training (E&T or TVR)					
22	General Education Diploma					
24	High School Completion					
26	Medical/Dental/Mental Health Appt.					
30	Subsistence (6 hours per week max)					
36	Substance Abuse Treatment/Counseling					
37	Parenting Skills Training (Ex. ILP, PLL)					
38	Life Skills Training (Ex. budgeting, KIHA)					
40	Provide Child Care for TANF Clients					
99	Other Activities Approved by Case Manager					
100	TANF Appointments/Meetings					
<b>TOTAL</b>						

<b>Participant Name:</b>	<b>Case Manager:</b>
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This calendar is for you to log the activities outlined on your Family Self Sufficiency Plan. You can include events, workshops or other trainings, parent/teacher conferences, medical appointments, childcare follow up, or other activities approved by your case manager. Remember to turn in this calendar once a month or as outlined on your Family Self Sufficiency Plan.

***IF HOURS NEED SIGNATURE VERIFICATION: PLEASE HAVE THEM INITIAL ON CALENDAR DAY OR ATTACH PROOF***

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Notes:</b>

**By signing below, I certify that all hours and activities claimed above are true and correct to the best of my knowledge.**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**