
"To Elevate the Quality of Life of the People We Serve"



KODIAK AREA NATIVE ASSOCIATION

Employment, Training, and Support Services Application

PHYSICAL LOCATION: 194 ALIMAQ DRIVE
MAILING ADDRESS: 3449 REZANOF DRIVE EAST
KODIAK AK 99615
PHONE: (907) 486-9879
FAX: (907) 486-4829
EMAIL: ETSS@KODIAKHEALTHCARE.ORG

Please tell us what services you would like:

- | | |
|---|---|
| <input type="checkbox"/> Temporary Cash Assistance | <input type="checkbox"/> Child Care Assistance |
| <input type="checkbox"/> Job Training/Education | <input type="checkbox"/> Higher Education/Vocational Scholarships |
| <input type="checkbox"/> Employment/Job Search Assistance | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Supplemental Youth Employment Training (SYETP) | <input type="checkbox"/> Other: _____ |

www.kodiakhealthcare.org

Application and assistance process:

1. Fill out application.
2. Turn in application with **ALL REQUIRED** documents for processing.
3. Application will be processed in 10 business days and you will receive notification in the mail on status (e.g. approved, denied, or missing documents)
4. Program Staff will contact you and provide supplemental program application/information
5. Complete supplemental documentation (if required)
6. Case Manager will schedule an intake meeting
7. Bring **ALL REQUIRED** supplemental documents to intake meeting

Required Items For Initial Eligibility (further documents may be needed for program specific assistance):

- Completed and signed application for services
- Proof of tribal enrollment or Certificate of Indian Blood
- Residency in the Koniag Region (Akhiok, Karluk, Kodiak, Larsen Bay, Old Harbor and Port Lions)
- Selective Services registration documentation (for male applicants 18 years or over)

Applicant Information:

Name: _____ SSN: _____ - _____ - _____

Physical Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

D.O.B _____ / _____ / _____ Currently reside in the Koniag Region ____ Yes ____ No

Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email Address: _____

Veteran ____ Yes ____ No Discharge Date: _____ Eligible Spouse ____ Yes ____ No

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Number of Persons in the Household: _____ Total Household Income per Month: _____

List income sources (e.g. paid employment, corporation dividends, SSI or disability, etc.): _____

Current Employment Status: ____ Employed ____ Unemployed ____ Not seeking work

Special needs: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Lack of appropriate clothing | <input type="checkbox"/> Dental care needs | <input type="checkbox"/> Trouble speaking or understanding English |
| <input type="checkbox"/> Lack of reliable transportation | <input type="checkbox"/> Health/medical problems | <input type="checkbox"/> Trouble with reading or writing |
| <input type="checkbox"/> Lack of food | <input type="checkbox"/> Inadequate child care | <input type="checkbox"/> Pregnancy needs |
| <input type="checkbox"/> Lack of money for daily expenses | <input type="checkbox"/> Inadequate housing | <input type="checkbox"/> Mental health concerns |
| <input type="checkbox"/> Physical limitations | <input type="checkbox"/> Drug/alcohol concerns | <input type="checkbox"/> Vision needs |
| <input type="checkbox"/> Disabilities | <input type="checkbox"/> Family problems | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Problems with child(ren) | _____ |

Are you requesting assistance for anyone in your household who is pregnant? _____ Yes _____ No

If yes, who? _____:

Is any adult in your household fleeing from prosecution, custody, or confinement? _____ Yes _____ No

Do you have an IEP or 504? _____ Yes _____ No

Have you received services from KANA Community Services before? _____ Yes _____ No

What are your future educational and/or career plans?

How can we help you with your plan?

PRIVACY ACT OF 1974 (PL 93-579) NOTICE OF RECORD SYSTEM

The US Congress has passed a law that requires every federal agency maintaining records about people to inform each person, from whom information is obtained, about the nature and purpose of the record. This includes employment and vocational training records maintained by the Kodiak Area Native Association Employment Assistance Program, contracted by the US Department of the Interior, Bureau of Indian Affairs and the US Department of Labor, Workforce Investment Act.

The purpose of the forms asked of you is to enable KANA staff to provide comprehensive employment and vocational training services to the people we serve. In some instances you may choose not to answer the questions without risk to your rights and entitlement. However, by giving the information requested, we will be able to carry out our responsibilities to you more effectively, and render better services.

Information provided by you is held in confidence and is released only with your written permission. For reporting requirements, data from your file will be submitted to the funding agency. However, the information submitted is used solely for statistical reports.

I CERTIFY THAT I UNDERSTAND THE AUTHORITY BY WHICH INFORMATION IS ASKED OF ME, THE PURPOSE AND USES TO WHICH THAT INFORMATION WILL BE PUT, AND THAT PROVIDING ANY INFORMATION IS VOLUNTARY ON MY PART.

Applicant Signature

Date

Applicant Signature

Date

Parent/Guardian Signature (if applicable)

Date

Applicant/Client Appeal Procedure

An applicant who was denied services or feels he/she may have been treated unfairly, has the right to file a written appeal (within 15 days after receipt of a decision) by completing the following procedure:

□ **Step 1 – Case Manager**

An applicant may file a written appeal to the Case Manager to ask for reconsideration of their decision. The Case Manager has ten (10) working days after the date stamped on the appeal to respond. An applicant, who is not satisfied with the Case Manager's decision, may submit their appeal to the Program Manager (Step 2) within five (5) days upon receipt of the Case Manager's decision.

□ **Step 2 – Program Manager**

The Program Manager has ten (10) working days from the date he/she receives an appeal to review documentation, make a decision, and respond. An applicant who is not satisfied with the Program Manager's decision may resubmit their appeal to the Appeal Committee (Step 3) within fifteen (15) days after receiving the Program Manager's decision.

□ **Step 3 – Appeal Committee**

The Appeal Committee will meet to review appeals submitted by applicants. The committee will notify an applicant of their decision within seven (7) working days after the date of their meeting.

All decisions made by the Appeal Committee are final.

Decisions affecting an applicant are made based on a review of program policies, procedures, and the required official documents. ***Reminder: An applicant only has fifteen (15) days after receipt of a decision to register an appeal.***

Certification and Agreement

Initial I (we) certify to the best of my (our) knowledge that the information and documentation contained in this application is accurate and true. I (we) also understand that additional information may be requested to verify what has been submitted.

Initial I (we) understand that my (our) application is subject to verification, and that falsification of information shall be grounds for immediate termination from the program and will subject me (us) to federal prosecution under 18 U.S.C. § 1001, which carries a fine of not more than \$10,000 or federal imprisonment for not more than five (5) years, or both. I (we) also understand that if I (we) receive services as a result of falsified information, I (we) will have to repay the Tribe for those services.

Initial I (we) understand and will comply with Goals and Activities outlined in the Self-Sufficiency Plan developed with my (our) Program Case Worker.

Initial I (we) understand that there is an Appeal Procedure by which I (we) can challenge a decision with regard to this application. I (we) certify that I (we) have received a copy of this Appeal Procedure, have read it, understand it, and will abide by it.

Initial I understand that I must give 100% effort while participating in the program & that I am responsible for my own success.

Applicant Signature

Date

Applicant Signature

Date

Parent/Guardian Signature (if applicable)

Date

How Your Rights Are Protected

The ETSS Case Manager will collect information, including the Social Security Number of each household member who is applying for assistance to determine eligibility for benefits. The Case Manager will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. Case Managers may disclose this information to other Federal and State agencies for official examination, to law enforcement officials for the purpose of apprehending persons seeking to avoid the law, and to private claims collection agencies for claims collection action. Case Managers may verify immigrant status of household members by contacting the US Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits. Providing the requested information, including the Social Security Number (SSN) of each household member for whom you are seeking benefits, is voluntary. However, failure to provide this information will result in the denial of benefits to each individual failing to provide a SSN. Any SSN provided will be used and disclosed in that same manner, regardless of the eligibility of the individual. Case Managers can assist you in applying for a Social Security Number if you are seeking benefits and do not have one. When you sign the application for assistance you consent to release medical records and information about yourself and any other person you are applying for.

(You can get an electronic copy of the Notice of Privacy Practices at <http://www.hss.state.ak.us/das/is/hipaa/pdfs/privatehealthcareinfo.pdf>. Request a printed copy by writing to the State of Alaska, DHSS Privacy Official, P.O. Box 110650, Juneau, Alaska 99811-0650 or by email at privacyoffical@health.state.us.)

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health & Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, contact USDA or HHA. Write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD). USDA and HHS are equal opportunity providers and employers.

If you have questions about the Americans with Disabilities Act of 1990, contact the Division of Public Assistance Civil Rights Coordinator at (907) 465-3347.