"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:

- ☐ Temporary Assistance for Needy Families
- ☐ Job Training/Education
- ☐ Employment/Job Search Assistance
- ☐ Supplemental Youth Employment Training (SYETP)
- ☐ Child Care Assistance
- ☐ Higher Education/Vocational Scholarships
- ☐ Other:_____
- ☐ Other:_____

Application and assistance process:

1. Fill out entire 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
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 For Initial Eligibility: (further documents may be needed for program specific assistance)

☐ Completed and signed application for services (all sections satisfied)
☐ Proof of Alaska Native or American Indian Status (Child Care Assistance based on child status)
☐ 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)

NOTE: Parent/guardian signatures indicating approval for services are required for non-emancipated youth under 18 years.

Applicant Information:

Name:_____ SSN:_____-_____-_____

Physical Address:_____

Mailing Address: _____

City:_____ State:_____ Zip Code:_____

Birth Date_____/_____/_____ Currently live in the Kodiak 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: _____ Native Child(ren) in home ☐ Yes ☐ No

Total Household Income per Month:_____

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

Special needs: (Check any that apply)

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

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?

_____

_____

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

We may need to contact persons or organizations that can verify your information to determine your eligibility and/or for aligning services. When we contact such persons or organizations, we tell them our name, title, and that we work for Kodiak Area Native Association. We are prohibited by law from telling them anything about you or about the nature of services you are receiving that are outside this release.

The information we most often need to verify entails Tribal Enrollment or Native lineage, your household's composition including income and resources, and to establish case and service collaboration among the below listed service entities.

CONCERNING (name):_____ DOB:_____

Person/Organization Releasing Information (initial below):

- (___) KANA Medical Department
- (___) KANA Behavioral Health Department
- (___) Foster Care Licensing Services
- (___) Office of Children's Services
- (___) Kodiak Island Borough School District (KIBSD)
- (___) Kodiak Island Housing Authority
- (___) Tribe (please specify); _____
- (___) Other: _____

Person/Organization Receiving Information: KANA Employment, Training, & Support Services
3449 Rezanof East, Kodiak, AK 99615
Phone Number: (907) 486-9879

Release the information initialed below:

- (___) Birth records, Tribal Enrollment, CIB
- (___) Medical/hospital records
- (___) Case Notes/records
- (___) Self Sufficiency plan/Family Case Plan/Collaboration
- (___) Financial information

And or:

- (___) _____

I hereby authorize the use or disclosure of my family's health care and/or other information as described above. I understand that **this authorization is voluntary** and that I may revoke this authorization at any time by providing written notification to cancel or to change it. I understand that KANA-ETSS Program services are funded by state and federal grants, and that the state, federal, and lead agencies assure that the information received is treated as confidential and is protected in accordance with applicable state and federal laws. I understand that if the person or entity that receives the information being used/disclosed may not be a health care provider or health plan covered by federal privacy regulations, the information may be subject to re-disclosure and no longer protected by these regulations.

This authorization expires on the following date:_____

_____ _____

Applicant &/or 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.