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"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](mailto:ETSS@KODIAKHEALTHCARE.ORG)

Please tell us what services you would like:

- |   |   |
|---|---|
| <input type="checkbox"/> Temporary Assistance for Needy Families <ul style="list-style-type: none"><li>○ Parent(s) and Child(ren)</li><li>○ Caregiver(s) and Child(ren)</li></ul> | <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](http://www.kodiakhealthcare.org)

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 Kodiak 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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender: \_\_\_\_\_ Tribal Affiliation: \_\_\_\_\_

Currently live in the Kodiak Region \_\_\_\_ Yes \_\_\_\_ No Email Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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)**

- |   |   |  |
|---|---|--|
| <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

Highest Grade you completed in school? Grade: \_\_\_\_\_

Do or Did you have an Individualized Education Program/Plan (IEP) or 504? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

Have you received cash assistance from the State of Alaska or another Tribal entity within the last 6 months? If so, where? \_\_\_\_\_ Yes \_\_\_\_\_ No

Location: \_\_\_\_\_

What are your future educational and/or career plans?

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How can we help you with your plan?

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# 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.

\_\_\_\_\_  
Initial I understand that if I don't turn in all of the required/requested documents to determine eligibility, my application(s) will not be complete and I may be denied for services.

\_\_\_\_\_  
Initial I understand that ETSS will collect information, including the Social Security Number of each household member who is applying for assistance to determine eligibility for benefits. This information will be verified with State, Federal, and Tribal partners, through computer programs, including but not limited to: Income and Earnings Verification System (IEVS), Eligibility Information System (EIS), and Alaska's Resource and Integrated Eligibility Services (ARIES).

\_\_\_\_\_  
Initial I understand that in accordance with federal law, KANA is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if applicable)

\_\_\_\_\_  
Date