KODIAK AREA NATIVE ASSOCIATION

KANA Workforce Development

Master Application

To Elevate the Quality of Life of the People We Serve

If you or someone you know needs assistance completing this application, please reach out to Workforce Development via the contact methods at the bottom of this page.

AVAILABLE SERVICES: *Please select the service(s) that you are applying for below:*

☐ Temporary Assistance for Needy Families (TANF)
☐ Child Care Assistance
☐ Job Training/Education
☐ Employment/Job Search Assistance
☐ Supplemental Youth Employment Training Program (SYETP)
☐ Higher Education/Vocational Scholarships
☐ General Assistance (GA)
☐ Community Services Block Grant (CSBG)*
    * *Village Residents Only*
☐ Tribal Vocational Rehabilitation (TVR)
☐ Adult Chore Services
☐ Other: _____

ELIGIBILITY REQUIREMENTS: *Additional documents may be needed for program-specific assistance.*

☐ Completed application (all sections satisfied)
☐ Provide proof of Alaska Native/American Indian status*
    **Child Care Assistance based on child status*
☐ Provide a copy of Driver's License or Identification Card
☐ Reside in the Koniag Region (Akhiok, Karluk, Kodiak, Larsen Bay, Old Harbor, Ouzinkie, or Port Lions)*
    **Akhiok and Port Lions Scholarship Applicants need not reside within the Koniag Region*
☐ Selective Service Registration (for male applicants 18 years or over)

APPLICATION AND ASSISTANCE PROCESS:

☐ Return completed Master Application with all required documents for processing. Completed applications will be processed within 10 business days - you will receive notifications via phone, email, or mail.
☐ Complete and return supplemental program application and documentation (if required).
☐ Schedule and attend an intake meeting with your Case Manager.

➤ **Parent/Guardian signatures are required for non-emancipated youth under 18 years of age.**

For Workforce Development Staff Only:

Date Received: _____ Received By: _____

KANA Workforce Development
Mailing: 3449 E Rezanof Drive Kodiak, AK 99615 | Physical: 111 W Rezanof Drive Kodiak, AK 99615
Phone: (907) 486-9879 | Fax: (907) 486-1340 | WorkforceDevelopment@kodiakhealthcare.org

APPLICANT INFORMATION:

Full Legal Name: _____

Also Known As: _____

Social Security Number: _____ Date of Birth: _____

Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Email Address: _____

Preferred Method of Contact: _____

Mailing Address: _____

City, State, & Zip Code: _____

Physical Address: _____

City, State, & Zip Code: _____

Gender at Birth: ☐ Male ☐ Female

Gender Identity (*Optional*): _____ Pronouns (*Optional*): _____

Veteran Status: ☐ Veteran ☐ Not a Veteran

Are you currently receiving Veteran services or benefits? ☐ Yes or ☐ No

Marital Status: ☐ Single, Never Married ☐ Divorced ☐ Widowed ☐ Married, Living Together

☐ Married, Separated ☐ Living Together as a Couple

Ethnicity: ☐ Alaska Native ☐ American Indian ☐ Not Native

Tribal Affiliation: _____ Enrollment Number: _____

Number of People in Household: _____ Housing Status: ☐ Own ☐ Rent ☐ Unhoused

Alaska Native/American Indian Children in Household? ☐ Yes or ☐ No

EDUCATION AND EMPLOYMENT INFORMATION:

Education Status: ☐High School Diploma ☐GED ☐Enrolled in Program ☐Applying for Education ☐N/A

Highest Grade Attended: _____ Last Year Attended School: _____

Employment Status: ☐ Employed ☐ Seeking Employment ☐ Unemployed

PROGRAMS:

Who were you referred to us by? _____

Have you or anyone in your household ever received similar assistance from KANA or other programs?

Examples: Workforce Development, State of Alaska, Sun'aq, etc. ☐ Yes or ☐ No

If yes, please list agency names, dates, and assistance received: _____

_____

BARRIERS TO SELF-SUFFICIENCY: *(Check all that apply)*

☐ Lack of Appropriate Clothing
☐ Lack of Reliable Transportation
☐ Lack of Money for Daily Expenses/Food
☐ Physical Limitations
☐ Disabilities
☐ Lack of Dental Care
☐ Health/Medical Problems
☐ Inadequate Child Care
☐ Inadequate Housing
☐ Drug/Alcohol Abuse
☐ Family Problems
☐ Problems with Child(ren)
☐ Difficulty Reading or Writing
☐ Pregnancy
☐ Mental Health
☐ Vision
☐ Individual Education Plan (IEP) or 504 in Place
☐ Difficulty Speaking, Understanding, Reading, or Writing in English
☐ Legal Barriers
☐ Other: _____
☐ Other: _____
☐ Other: _____

*To complete your application, the following questions **must** be answered.*

1. What are your educational, vocational, or other plans to reach self-sufficiency?

_____

_____

_____

2. What challenges are preventing you from attaining your goals?

_____

_____

_____

3. How can we assist you with your plan?

_____

_____

_____

4. Are you ready, willing, and able to work? ☐ Yes or ☐ No (*If no, please explain*):

_____

_____

_____

AGREEMENT AND UNDERSTANDING: *(Please initial each section and sign below)*

As a participant in the Workforce Development programs, I understand and agree to the following:

_____I understand that a Workforce Development staff member and I will develop a Self-Sufficiency Plan, which will outline my plan and necessary steps to achieve my goals and become self-sufficient.

_____I will provide all additional information and documents requested by Workforce Development staff in order to verify my eligibility in the program and to help build and maintain my Self-Sufficiency Plan.

_____I will take the necessary steps to achieve my goals included in my Self-Sufficiency Plan, with guidance from Workforce Development staff.

_____I will attend all scheduled meetings to the best of my ability. If I cannot attend the meeting, I will provide advance notice and work with program staff to reschedule the meeting as soon as possible.

_____I understand that Workforce Development may collect or verify information with Tribal partners and local, state, and federal agencies.

_____I understand my personal information will be treated in a confidential manner, and that KANA cannot disclose any information obtained during my application and program involvement unless I provide written consent, except as provided by law.

_____I will be treated with respect and dignity by Workforce Development staff, and I will also treat staff with respect to ensure personal safety of all. I understand that if threats of any kind are made to Workforce Development staff, the department has the right to refuse and/or terminate services.

_____I have received a copy of, and understand, my rights in the Workforce Development Appeals Process.

_____I certify that the information I provided in this application is true and correct to the best of my knowledge, and I understand that I must continue to provide accurate and complete information to Workforce Development staff throughout my participation in the program.

_____ _____

Applicant Signature Date

_____ _____

Parent/Guardian Signature (if under 18) Date

_____ _____

Workforce Development Staff Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION:

KANA Workforce Development may need to contact others that can verify your information to determine your eligibility. The information we most often need to verify is Tribal Enrollment or Alaska Native/American Indian lineage, and your household composition, income, and resources. We may also need to verify or coordinate casework and services you are receiving from other KANA programs, or other entities.

Even with this release, we do not request or share information beyond what you have authorized that is necessary for your services and our operations. Workforce Development treats all information received from you or from others releasing information to us as confidential and protected, in accordance with applicable state and federal laws.

Other programs and entities (especially clinics and hospitals) may also require their own Release of Information (ROI) form to be completed.

Concerning (Name): _____ **DOB:** _____

For the purpose of (*check all applicable*)

☐ Verifying KANA Workforce Development Application Information ☐ Coordinating Services/Care Plans

☐ Other: _____

Release information to and from KANA Workforce Development and the following *(check all applicable)*

☐ KANA Medical Department (*also requires separate ROI)*
☐ KANA Behavioral Health Department (*separate ROI)*
☐ KANA Elder Services
☐ KANA Child & Family Services (Tribal Victim Services, Family Violence Prevention, Indian Child Welfare, Cama'i Home Visiting, Infant Learning Program)
☐ AK Dept. of Public Assistance
☐ AK Office of Children's Services (OCS)
☐ Kodiak Island Borough School District (KIBSD)
☐ Kodiak Island Housing Authority (KIHA)
☐ U.S. Bureau of Indian Affairs (BIA)
☐ Tribe: _____
☐ Corporation: _____
☐ Other: _____

Release this information *(check all applicable)*

☐ Birth Records
☐ Tribal Enrollment/Certificate of Indian Blood
☐ Financial Information
☐ Medical Records (*also requires separate ROI)*
☐ Case Notes (*also requires separate ROI)*
☐ Other: _____

I hereby **authorize the use or disclosure of my information as described above**. This authorization will remain in effect **up to one year after I receive Workforce Development services, or until revoked in writing** at any time. I understand that disclosed information **may be subject to redisclosure** by KANA or others in certain situations, subject to applicable regulations. I understand that this authorization is **voluntary**, and that my refusal to sign will not affect my ability to obtain services or be eligible for benefits.

_____ _____
Applicant Signature Date

_____ _____
Parent/Guardian Signature (if under 18) Date

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APPLICANT APPEAL PROCESS FOR WORKFORCE DEVELOPMENT:

An applicant has the right to appeal any decision made by Workforce Development regarding their services. The appeal process is to be conducted in writing and within the specified time frames. An applicant may withdraw their appeal at any point during the three-step process detailed below.[1]

Step 1: Participant

Participants must provide a written complaint to the Program Supervisor (Employment and Training Manager or Support Services Coordinator) within five business days of the unsatisfactory decision. Complaints must include details and the desired action or remedy. To submit:

Email:	**Mail:**	**Drop-Off:**
workforcedevelopment@kodiakhealthcare.org	Attn: Workforce Development 3449 E. Rezanof Drive Kodiak, AK 99615	Attn: Workforce Development 111 W. Rezanof Drive Kodiak, AK 99615

Step 2: Program Supervisor

The Program Supervisor has five business days to meet with and respond to the participant's complaint. If the grievance is not resolved during the meeting with the Program Supervisor, the participant may proceed to Step 3.

Step 3: Grievance Committee

Should the participant be unsatisfied with the determination made by the Program Supervisor, the participant must submit a written complaint within five business days of the Program Supervisor's response. Once the written complaint is received, a Grievance Committee will convene within five business days of receipt, to consider the participant's complaint. Once convened, the Grievance Committee has five business days to then respond to the participant's complaint with a final decision.

[1] In addition to this Appeal Process for Workforce Development Services in general, Vocational Rehabilitation clients may also contact the Alaska Statewide Independent Living Council Client Assistance Program (CAP), a client advocacy organization that may be able to provide client assistance or support. For more information call 1-800-478-0047 or see https://www.alaskasilc.org/resources/client-assistance-program/