TANANA CHIEFS CONFERENCE
APPLICATION FOR WELFARE ASSISTANCE

******INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED******

Name: _____ **SS#:** _____

Maiden Name or Other Names Used: _____ **Date of Birth:** / /

Mailing Address: _____
P O Box or Street Address City State Zip

Physical Address: _____
Street Address City State Zip

Home Phone#: _____ **Message Phone#:** _____ **Work Phone#:** _____

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

List ALL MEMBERS of the Household. Enter an asterisk (*) in the box at left of the name for each person NOT INCLUDED in General Assistance application budget.

*	NAME	RELATION TO HEAD	DATE OF BIRTH	SEX	SOCIAL SECURITY #	TRIBE ENROLL #	MONTHLY INCOME

MEMBERS OF HOUSEHOLD WITH PHYSICAL OR MENTAL HANDICAP

NAME	NATURE OF PROBLEM	TEMPORARY or PERMANENT	MINOR or MAJOR	VERIFIED

How many persons live in the house: _____ **Adults** _____ **Children**

Type of Service Applying for: ☐General Assistance ☐Emergency *for home burnout, flooding, etc. NOT for eviction/shutoff notices, medical travel, funeral travel, etc. per 25 CFR Part 20 §20.329.

Where do you live now? ☐Own Home ☐Rent House/Apartment ☐Rent Room ☐With Relatives ☐With Friend(s) ☐Other: _____

Are you or any member of your household a shareholder in a Native Corporation? ☐Yes ☐No
If yes, list the name of household member and Corporation(s) here: (use backside of form if necessary)

MEMBERS OF HOUSEHOLD WHO OWN SHARES IN A NATIVE CORPORATION

NAME	NATIVE CORPORATION	# SHARES OWNED

Have you received ATAP or TANF in the last month:	☐Yes	☐No	If yes, how much: $_____
Has your ATAP/TANF been reduced due to penalties:	☐Yes	☐No	Reason:_____
Have you been terminated from ATAP/TANF:	☐Yes	☐No	Date of termination:___/___/___
Have you been determined ineligible for ATAP/TANF:	☐Yes	☐No	Reason:_____
Have you been denied ATAP/TANF:	☐Yes	☐No	Reason:_____
Are you eligible to reapply for ATAP/TANF:	☐Yes	☐No	Date able to reapply:___/___/___
What TANF office did you receive assistance from:	Please list:_____		

EXPLAIN *FULLY*, how you have supported yourself during the past three (3) months *and* what has changed in your situation to cause you to apply for assistance. Failure to complete this section will render this application incomplete & therefore will not be processed.

_____

_____

_____

_____

_____

RECORD OF INCOME AND RESOURCES

Does anyone in your household have income from any source? ☐Yes ☐No

If yes, list the name of household member(s), source of income and amounts below.

******YOU ARE REQUIRED TO REPORT INCOME RECEIVED FROM THE FOLLOWING******

SOURCE OF INCOME & RESOURCES	AMOUNT	NAME OF HOUSEHOLD MEMBER
Salary #1: Applicant's Income/Salary	$	
Salary #2: Spouse's Income/Salary	$	
Tips or Gratuities	$	
ATAP –TANF-ASAP (State assistance)	$	
Child Support and Alimony	$	
Foster Care Payments	$	
Adult Public Assistance (APA)	$	
Social Security (SSA)	$	
Supplemental Security Income (SSI)	$	
Disability Insurance	$	
Alaska State Permanent Fund (PFD)	$	
Cashouts of Retirement or Pension Plans	$	
State Longevity	$	
Veteran's Benefit	$	
Unemployment Insurance Benefits	$	
Worker's Compensation	$	
Food Stamps	$	
Medicare/Medicaid	$	
Native Corporation Dividends	$	
Checking Account	$	
Savings Account	$	
Student Loans/Grants/Scholarships	$	
Bingo or Pull Tab Winnings	$	
Other Income	$	
TOTAL MONTHLY INCOME	$	

MONTHLY SHELTER COSTS

PROVIDE ALL EXPENSES FOR THE CURRENT MONTH

Rent	$	Telephone	$
Space Rent	$	Water	$
Mortgage Payment	$	Sewer	$
Electricity	$	Household Oil/Fuel/Wood	$
Heating	$	Other	$

READ BEFORE SIGNING

I/We apply for financial assistance/ services for the listed members of my (our) household who are in need. I/We have received a copy of and have had explained to us, and understand the provisions of Federal Law governing fraud.

☐ Applicants or recipients who knowingly and willfully provide false or fraudulent information are subject to prosecution under 18 U.S.C. §1001, the Federal Law concerning fraud which carries a fine of not more than $10,000 or imprisonment of not more than five years or both. Initials of applicant_____

☐ I (We) agree to supply information regarding resources and income and to notify the agency of any changes in my (our) situation. Release of Information: Human Services is authorized to obtain/exchange information necessary to establish eligibility for assistance. I (We) have read, or had explained to me/us, the provision of our protection under the Paperwork Reduction Act and the Privacy Act. Initials of applicant_____

_____ Applicant Signature

_____ Signature of Other Adult Household Member

_____ Printed Name

_____ Printed Name

_____ Date

_____ Date

_____ TWDS or Tribal Representative Signature

_____ Date

**********FOR OFFICE USE ONLY**********

Date Application Received:_____ Application Received By:_____

DECISION OF APPLICATION: ☐ Approved ☐ Denied Date:___/___/___

(Review Dates: ___/___/___ 1-Month Review ___/___/___ 3-Month Review ___/___/___ 6-month Review)

COMMENTS/NOTES:_____

Caseworker Signature:_____ Date:___/___/___