



"Yee gu.aa yax x'wan."

**An Indian Reorganization Act Village
Under Act of Congress June 15th, 1935**

32 Chilkat Ave. Klukwan, Alaska 99827
HC60 Box 2207 Haines, Alaska 99827
Phone: 907-767-5505
Fax: 907-767-5408
klukwan@chilkat-nsn.gov

Application for 477 Services

What kind of assistance are you requesting?

(CHECK ALL THAT APPLY)

- Child Care
- Job Placement and Training
- General Assistance
- Adult Higher Education

Name of Client: _____ Date of application: _____

Phone # _____

Address: _____

*****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:

477 Caseworker Signature: _____ Date: ____/____/____

Application Instructions:

1. Fill out the 477 application.
2. Complete the additional application for the service(s) you are requesting.
3. Fill in **all** blanks in the application. If a blank does not apply to you, please write "NA".
4. The following documents must be submitted with your application. *Your application will be considered incomplete without these documents and will not be processed:*
 - Tribal enrollment card or Certificate of Indian Blood for everyone in your household.
 - Birth Certificate of child (Child Care Assistance only)
 - Copy of Driver's License or other State or Federal identification.
 - Copy of Social Security card or Social Security number.
5. Make sure you sign and date your application.

Eligibility Requirements for Chilkat Indian Village services:

In order to be eligible, you must:

- Be an enrolled member of a federally recognized tribe and living within our service area. (Higher Education Scholarships do not have a residency requirement but you must be Chilkat Indian Village enrolled member).
- Submit a copy of your BIA Certificate of Indian Blood (CIB) or Chilkat Indian Village Tribal enrollment card verifying Indian Blood Quantum.
- All males 18 to 25 must provide proof of enrollment with Selective Service.
- Meet all eligibility requirements for the program(s) to which you are applying.
- Must be unemployed or underemployed and economically disadvantaged. (Higher Education Scholarships do not have a economical requirement.)
- Demonstrate ability to obtain employment based upon training request. (Higher Education Scholarships and Child Care does not apply.)

Please note:

Incomplete applications cannot be processed until all information and documentation required to complete the application has been received by Chilkat Indian Village.

Who do I contact if I have any questions, need more information, and/or need assistance in completing my application?

For employment services, scholarships, general assistance and child care assistance:

Please call the 477 Case Manager: (907) 767-5505

APPLICANT INFORMATION/PERSONEL DATA			
Name (First, Middle, Last) Male/Female		Sex	Date of Birth
Home Address (Physical Location)		City	State/Zip code
Mailing Address		City	State/Zip code
Home Phone		Cell Phone	Message Phone
Emergency Contact/ Relationship	Phone number of emergency contact	Personal Email Address	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Single living with significant other <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Family Status <input type="checkbox"/> Parent in one-parent family <input type="checkbox"/> Parent in two-parent family <input type="checkbox"/> Number of dependents under 18 in household _____ <input type="checkbox"/> Total Number in household _____	Have you applied for Chilkat Indian Village Services before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____	
Are you enrolled with the Chilkat Indian Village Yes / No	Tribal Enrollment Number	Social Security Number	
Do you have a misdemeanor or a felony record? Y / N If yes please explain:			
If you are a male between the ages of 18 to 25, have you signed up for selective services? Y / N NA			
Have you received ATAP or TANF in the last month: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much: \$ _____			
Have you been determined ineligible for ATAP/TANF: <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____			
Are you eligible to reapply for ATAP/TANF: <input type="checkbox"/> Yes <input type="checkbox"/> No Date able to reapply: __/__/__			
Sign Here X			Date

Family Income and Available Funds

List ALL sources of income that you or your family members will receive during the next 30 days and current available funds. You must provide verification of income from your employer.

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	\$	
Cashouts of Retirement or Pension Plans	\$	
Food Stamps	\$	
Checking Account	\$	
Savings Account	\$	
Native Dividends	\$	
Other	\$	
Other	\$	

Anticipated total income \$ _____

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CERTIFICATION AND AGREEMENT

I (we) certify to the best of my 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.

I (we) understand that my application is subject to verification, and that falsification of information shall be grounds for immediate termination from the program and will subject me 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 years, or both. I (we) also understand that is I (we) receive services as a result of falsified information, I (we) will have to repay the Tribe for those services.

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

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.

Applicant Signature

Date

Applicant Signature

Date

Printed name of applicant

Print name of applicant

Parent/Guardian Signature

Date

Redetermination Date (3 months: ISP)/ (6 months: Case Plan)
 (mm/dd/yyyy)/ Initials: ____/____/____ / _____

Date Recipient met ALL goals (mm/dd/yyyy)
 (mm/dd/yyyy)/ Initials: ____/____/____ / _____

INDIVIDUAL SELF-SUFFICIENCY (ISP)/ CASE PLAN (25 CFR Part 20)

ISP / Case Plan [Check all that Apply]

Name of Client: (Last, First, Middle): _____ Date of Plan: ____/____/____

What is/are your goals to achieve self-sufficiency?

Short-Term Goals:

Long-Term Goals:

BARRIERS TO CLIENT			STRENGTHS OF CLIENT
<input type="checkbox"/> Health	<input type="checkbox"/> Lack of/ Limited Transportation	<input type="checkbox"/> No Driver's License	<i>Identify strengths the client possesses:</i>
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lack of/ Limited Education	<input type="checkbox"/> Social Isolation	
<input type="checkbox"/> Substance Abuse Dependency	<input type="checkbox"/> Criminal History	<input type="checkbox"/> Limited/No Jobs Available	
<input type="checkbox"/> Age Factors	<input type="checkbox"/> Limited/ No Work History	<input type="checkbox"/> Homeless	
<input type="checkbox"/> Disabilities	<input type="checkbox"/> No Job Skills	<input type="checkbox"/> Other: _____	

STEPS NEEDED TO ACHIEVE SELF-SUFFICIENCY

WORK ACTIVITIES	EDUCATION/ TRAINING	OTHER ACTIVITIES	CASE PLAN
<input type="checkbox"/> Job Search	<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Life Skills Activities	<input type="checkbox"/> SSA Application
<input type="checkbox"/> Volunteer Work Experience	<input type="checkbox"/> GED	<input type="checkbox"/> Parenting Skills	<input type="checkbox"/> Medical Report
<input type="checkbox"/> Job Sampling or Job Shadow	<input type="checkbox"/> ESL (English as 2 nd Language)	<input type="checkbox"/> Childcare Assistance	<input type="checkbox"/> Decision Letters
<input type="checkbox"/> On-the-Job Training	<input type="checkbox"/> Adult Vocational Training	<input type="checkbox"/> Child Support	<input type="checkbox"/> Legal Assistance
<input type="checkbox"/> Employment Counseling	<input type="checkbox"/> Literacy Improvement	<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Care for Child Under Age 6
<input type="checkbox"/> Registration with Local Job Service	<input type="checkbox"/> Higher Education	<input type="checkbox"/> Counseling	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Job Readiness	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Driver's License Reinstatement	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Dental/Health Care	
		<input type="checkbox"/> Other: _____	

SELF SUFFICIENCY ACTION PLAN & GOALS

GOAL #1		
Goal #1 Revised		
ACTION STEPS FOR GOAL #1	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		
GOAL #2		
Goal #2 Revised		
ACTION STEPS FOR GOAL #2	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		
SOCIAL SERVICES WORKER'S ACTIVITY WITH TIMEFRAME (25 CFR 20.318)	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

____ I understand that the purpose of the Individual Self-Sufficiency Plan (ISP) is to meet the goal of employment through specific action steps and I am required to follow the steps developed in the ISP. I understand that I must participate in work activities and/or other activities and referrals developed in this plan that will promote my self-sufficiency. Failure to follow through with the ISP may constitute suspension from the General Assistance Program for a period of at least 60 days but not more than 90 days. I also understand that if there are any changes to be made that I will contact my Case Worker in a timely manner to ensure my success in the General Assistance Program.

____ I understand that the purpose of the Case Plan is to follow through with goals listed: (i.e.) Accessing other resource programs, keeping medical appt., etc. Failure to follow through with the steps identified in the Case Plan may constitute suspension from the General Assistance Program.

 Recipient Signature

 Date Signed

 Social Services Worker Signature

 Date Signed

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AUTHORIZATION
FOR RELEASE OF INFORMATION

I _____ authorize the release of information requested by the Chilkat Indian Village or its tribal service staff. The requested information will only be used in the administration of the 477 program, and will not be released to any other person or agency outside of the Chilkat Indian Village office or its tribal service staff. This release of information will be in effect while I am an applicant or recipient of the 477 program, and for any later investigations of my eligibility and receipt of benefits.

Persons or organizations that may be contacted include, but are not limited to: the Department of Law, the Department of Public Safety, the Department of Fish and Game, the Department of Labor, the Department of Military & Veterans Affairs, the Department of Revenue, the Bureau of Citizenship and Immigration Services, Alaska Housing Finance Corporation, Social Security Administration, local governments, public assistance program contractors and grantees, tax assessors, financial institutions, Native corporations, stock brokerage firms, landlords, employers, school authorities, and private individuals.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

Table with 2 columns and 3 rows: Printed Name, Signature, Address, Social Security Number, Phone Number, Date.

Appeal Rights

All applicants of the program have the right to make a written request to appeal all decisions and actions being made on their 477 self sufficiency program services. Each time a client makes a written request for reconsideration in filing an appeal, the request must contain the following:

1. The reason for the dispute and why the client disagrees with the decision, action or findings of the staff that made the decision/action.
2. The issue involved in the dispute.

All written request must be made within twenty (20) working days from the date the letter of notification was written. The request for a formal appeal must be submitted to Tribal Administrator, Chilkat Indian Village, HC 60 2207, Haines, AK, 99827 or it can be hand delivered to the Tribal Administrator. If you do not request within the twenty (20) days, the decision will become final and not subject to appeal under 25 CFR Part 20. If you are dissatisfied with the Tribal Administrator's written decision after the formal hearing then you may submit your request for another formal appeal hearing within twenty (20) days of the tribal formal hearing's written decision. This request should be directed to the Bureau of Indian Affairs, Regional Office of Human Services, P.O. Box 25520, Juneau, Alaska, 99802. You may have representation, at your own expense for either of the formal hearings.

Chilkat Indian Village

CHILD CARE ASSISTANCE

Child care assistance is available to low income-eligible parents who reside in the Haines and Klukwan area and who are employed or undergoing training. The program pays a percentage of child care costs incurred when the parent(s) are engaging in employment or school. Parents are urged to apply for employment services and/or higher education assistance to enable them to obtain reasonable employment and self-sufficiency. Children aged 13 and above are not eligible for program benefits.

The process for calculating funds for Childcare

The parents must provide proof of income for the previous 12 months at time of application. The CIV takes the previous twelve months income plus the size of that family and compare to a household medium income sliding scale. The sliding scale is an income range which tells us of how much parents are responsible for and CIV is responsible for payments. We will need proof of family income on a monthly basis.

Parent Application Check List: *The application will not be approved until these documents are received.*

- Income: Paystubs, Unemployment stubs, GA/ Public assistance letters, Native Distributions, Bank loans, Personal loans, Longevity, PFD, SSI, Tax return and training / work schedule.
- Fully completed application
- Child and parent identification, birth certificates, tribal enrollment and age appropriate immunization records

Provider Application Checklist:

- Licensing, Business License
- Medical Testing, TB Testing
- CPR & First Aide, Acquire CPR & First Aide card
- Background check, Acquire background check from the Trooper/Haines Police
- Have medical release from parents for medical treatment for child(ren)

The Day Care Provider responsibilities

All paperwork must be submitted to the CIV office by the 5th of every month for the previous month expenses. Time sheets from the provider for time they cared for the child or children.

The CIV has ten days after receiving all paperwork in which to determine how much CIV is responsible for and how much the parent(s) are responsible for, before we distribute payment.

I the provider and parent understand this policy and will not expect payment on the same day a time sheet is turned in. I also understand that it is my responsibility not the CIV office's to report my income to the IRS, when tax time arrives.

Signature of Parent _____ Date _____	Signature of Provider _____ Date _____
---	---

List ALL MEMBERS of the Household. Enter an asterisk (*) in the box at left of the name for each child under the age of 13 included in the Child Care application.

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

*	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

Providers name:	Childs Name:
Providers Signature:	Parents Signature:
Providers Address:	477 Case Manager Signature:

Billing Month:

Date/Day	Time in/Time Out	Time in/Time Out	Total hours		
1 st			P/T	F/T	H
2 nd			P/T	F/T	H
3 rd			P/T	F/T	H
4 th			P/T	F/T	H
5 th			P/T	F/T	H
6 th			P/T	F/T	H
7 th			P/T	F/T	H
8 th			P/T	F/T	H
9 th			P/T	F/T	H
10 th			P/T	F/T	H
11 th			P/T	F/T	H
12 th			P/T	F/T	H
13 th			P/T	F/T	H
14 th			P/T	F/T	H
15 th			P/T	F/T	H
16 th			P/T	F/T	H
17 th			P/T	F/T	H
18 th			P/T	F/T	H
19 th			P/T	F/T	H
20 th			P/T	F/T	H
21 st			P/T	F/T	H
22 nd			P/T	F/T	H
23 rd			P/T	F/T	H
24 th			P/T	F/T	H
25 th			P/T	F/T	H
26 th			P/T	F/T	H
27 th			P/T	F/T	H
28 th			P/T	F/T	H
29 th			P/T	F/T	H
30 th			P/T	F/T	H
31 st			P/T	F/T	H

Total P/T (Office use only)	Total F/T (Office use only)	Total H (Office use only)

CCDF Provider Rate Sheet

Name / Facility	Effective Date
Physical Address	Mailing Address
City	State / Zip
Phone	SSN#
Business License #	Checks payable to

Type of facility

Center Licensed

Group Home

Home Licensed

Family Home

Attendance rates listed are state rates.

	Infant 0-18 Months	Toddler 19-36 months	Preschool 37 to 6 years	School age 7 - 12 years
Monthly	520.00 F/T 300.00 P/T	492.00 F/T 300.00 P/T	450.00 F/T 275.00 P/T	450.00 F/T 275.00 P/T
Daily	31.00 F/T 19.00 P/T	30.00 F/T 18.00 P/T	26.00 F/T 16.00 P/T	26.00 F/T 15.00 P/T
Hourly	4.00	3.50	3.25	3.00

P/T is 0-5 hours

F/T is 5-10 hours

hourly is 2 hours or less.

I will notify Tribal Services of any changes a week prior. All charges are shown above.

Providers' signature _____ Date _____

Tribal Services Signature _____ Date _____