General Assistance Application

Program Description:
The Cheyenne and Arapaho Tribes provide assistance to federally recognized American Indian and Alaskan Native Tribal members in the following ways:

General Assistance: Cash assistance to meet essential needs of food, clothing, shelter, and utilities. Additionally, each General Assistance recipient must work with a social services worker to develop a signed and agreed upon Individual Self-Sufficiency Plan (ISP) to meet the goal of employment. The plan must outline specific steps individuals will take to increase their independence. Eligibility will be reviewed on either a three-month or six-month basis, or whenever there is change in status affecting eligibility. Recipients must immediately inform their Social Services Caseworker of such changes. If a client refuses employment or quits a job under the agreement of their ISP, he/she will be sanctioned and made ineligible for services for a minimum of 60 days, not to exceed a period of 90 days.

General Program Requirements:
Individuals must meet all of the following eligibility criteria:

1. Be enrolled member of a federally-recognized American Indian/Alaskan Native tribe,
2. Prove their inability to meet the essential need of food, clothing, shelter, and utilities,
3. Reside in an 11 county approved service area (Blaine, Beckham, Canadian, Custer, Dewey, Kingfisher, Roger Mills, Washita, Major, Woodward, or Ellis)
4. Apply concurrently for all the other federal, state, tribal, county, and local programs for which he/she may be eligible, and
5. Shall not be receiving any comparable assistance.

Items to Bring:

1. Verification of residence (Rent receipt, and utility bill OR written statement from homeowner)
2. Verification of tribal enrollment (CDIB/Tribal membership card)
3. Statement verifying whether or not employment benefits are being received
4. Verification of any and all income
5. Verification of a submitted/pending application or denial letter to TANF or SSI if eligible
6. Physicians statement verifying inability to work and anticipated amount of time (if claiming temporary disability)
Privacy Act Statement

25 CFR Part 20 and 25 U.S.C. 13 authorize the collection of this information. The information is confidential and is never disclosed without written clearance and consent of the applicant. The primary use of this information is to determine eligibility for financial assistance and services from the Bureau of Indian Affairs (BIA) Child Welfare, Burial, and Disaster programs. Additional disclosures of the information may be to other BIA or tribal officials in the conduct of their official duties pertaining to the application for financial assistance or services, or in the conduct of program review and to the Office of the Inspector General or the General Accounting Office when conducting an audit of BIA programs, or local law enforcement agency when the agency aware of violation or possible violation of civil or criminal law, and to the General Services Administration in connection with its responsibility for records management. This information will be entered into the BIA, Social Services system of records which can be obtained upon request from Chief, Division of Social Services, 1849 C Street, NW, MS-4513-MIB, Washington, DC 20240. No record contained therein may be disclosed by any means of communication to any person, or to another agency, except pursuant to a request by, or with prior written consent of the individual to whom the record pertains. Executive Order 9397 authorizes the collection of your Social Security number. Furnishing the information is voluntary but failure to do so may result in disapproval of your application. If the BIA uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

Paperwork Reduction Act Statement

The information is being collected to determine applicant eligibility for financial assistance and services to provide Bureau of Indian Affairs (BIA) managers with information for program planning, reporting and utilization. Response to this collection is required to obtain a benefit(s) required in 25 CRF 20. A Federal Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting for this form is estimated to average 1 hour per response, including the time for reviewing instructions, gathering and maintaining data, and completing the form. Direct comments regarding the burden estimate or any other aspect of this form to: Office of Regulatory Affairs & Collaborative Action – Indian Affairs, Information Collection Clearance Officer, 1849 C Street, NW, MS-4141, Washington, DC 20240.

__________________________ _______________________
Client Signature Date
Federal Law Governing Fraud

"Whoever, in any matter with jurisdiction of any Department or Agency of the United States, knowingly and willingly falsifies, conceals, or covers up by trick, scheme, or devises a material fact, or makes any false, fictitious, or fraudulent statement or representations or makes or uses any false writing or document, knowing the same to contain false, fictitious, or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five (5) years or both."

I (We), have read, or heard or have had interpreted to me (us) the preceding provisions of law and understand them. I (We), agree to supply all necessary information about my (our) household, employment and to notify the Agency when my (our) situation changes. I (We), also authorize the Bureau of Indian Affairs to obtain information necessary to establish my (our) eligibility for General Assistance.

"ALL APPLICANTS SHALL BE NOTIFIED IN WRITING, BY MAIL, OR GIVEN IN HAND, REGARDING THE DECISION AND ACTIONS ON THEIR APPLICATION, INCLUDING THE AMOUNT OF THE GRANT, IF APPROVED"

APPLICANT SIGNATURE ___________________________ DATE ___________________________

SPouse SIGNATURE ___________________________ DATE ___________________________
Social Services of the Cheyenne and Arapaho Tribes
APPLICATION for General Assistance

Name: ___________________________ Tribe: ___________________________

Also known as: __________________ Phone Number: __________________

Cell/MSG number: __________________

Mailing Address: __________________

Physical Address: __________________

Provide directions on how to get to your Home: __________________

1. Reason for applying for General Assistance? __________________

2. What type of income have you been living on for the last three (3) months? __________________

Section 1: FAMILY PROFILE OF HEAD OF HOUSEHOLD MEMBERS APPLYING (25 CFR §20.308)
Family Profile

Fill in all required blanks for everyone who lives with you, either permanently or temporarily. You must list yourself first, then your spouse and other adults and children. Place an asterisk (*) to the left of each person not included in payment.

<table>
<thead>
<tr>
<th>Members of Household</th>
<th>Birthdate</th>
<th>Sex</th>
<th>Relationship</th>
<th>Social Security Number</th>
<th>Tribal Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Applicant</td>
<td>Month/Day/Year</td>
<td>M/F</td>
<td>(self)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Client Background Summary

Client Name: ________________________________ Age: ______

Family Status: Single  Married (legal or common law)  Divorced  Separated  Widowed

Spouses Name: ____________________________ (Maiden Name) __________________

Number of Children: ______ Children not in home: ______ Adults in home: ______

Current Living Situation:  Own Home  Rent  Staying w/ someone  Section 8  Homeless

Other (please explain): __________________________________________________________

Do you have an IIM Account?  YES  NO  Does Spouse?  YES  NO

Date last employed: Applicant _____/_____/______ Type of job: __________________________

Highest grade completed: ______  Training or College? __________________________

What does spouse plan to do now? ______________________________________________

How have you been making it since your last job, support, or provider? ________________________________

How has your situation change for you to need assistance at this time? ________________________________

What is your greatest need at this time (i.e. utility bill, rent, medicine)? ________________________________

How do plan to improve your situation? ______________________________________________

Comment: ________________________________________________________________
Section III. EARNED INCOME & UNEARNED INCOME (25 CFR §20.308-§20.310)

Is anyone in the household currently working or have they worked in the past 30 day's ____Yes ____No
If yes, identify Household Member(s) who are working and their earnings:
Household Member #1 _______________________________ Amount $: __________
Household Member #2 _______________________________ Amount $: __________
Household Member #3 _______________________________ Amount $: __________
Do you expect to receive or are receiving any of the following listed below? ____YES ____NO
(If yes, put a check in front of all unearned income (not from employment) received by any household members, use additional space for further explanation.)

EARNED INCOME

____Wages/Salary Amount: $ __________
____Alimony/ Child Support Amount: $ __________
____Gifts/ Contributions Amount: $ __________
____Income Tax Refund (Federal/State) Amount: $ __________
____Insurance Settlement Amount: $ __________
____(Auto accident; etc.) Amount: $ __________
____Interest/Dividends (Bank Accounts) Amount: $ __________
____Lease Income (List) Amount: $ __________
____Lottery/Gaming Income (Cash Winnings) Amount: $ __________
____Retirement Benefits/Pensions Amount: $ __________
____Royalties Amount: $ __________
____Tribal per capita payments Amount: $ __________
____Social Security Amount: $ __________
____(Survivor/Disability Benefits) Amount: $ __________
____Unemployment Benefits Amount: $ __________
____Veteran's Benefits Amount: $ __________
____Worker's Compensation Amount: $ __________
____Benefits Amount: $ __________
____Farm/Ranch Income Amount: $ __________

TOTAL: Amount: $ __________

UNEARNED INCOME

Supplemental Security Income (SSI) Amount: $ __________
TANF Amount: $ __________
Food Stamps Amount: $ __________
Commodities: ____YES ____NO Amount: $ __________
Foster Care Payments other (List) (i.e. Alaska Native Corporation Dividend)
1. Amount: $ __________
2. Amount: $ __________

TOTAL: Amount: $ __________

Have you applied for TANF? ____YES ____NO Date: __________
Have you been terminated from TANF past 90 days? ____YES ____NO
Are you eligible to reapply for TANF? ____YES ____NO
Have you applied for other Resources/Program? ____YES ____NO Date: __________

Section IV. STATEMENT OF COOPERATION

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 concerning fraud. Under 18 U.S.C. §1001, the Federal Law concerning fraud states: "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or devise a material fact, or makes or uses any false writing or document and knowing to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both. 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 for services is authorized to obtain/exchange information necessary to establish eligibility for assistance. I (We) have read, or had explained to me (us), this for our protection under the Paperwork Reduction Act and the Privacy Act.

Please check:

____Read, Understood & Signed the Fraud Statement
____Read, Understood & Signed the Paperwork Reduction Act
____Read, Understood & Signed the Information of Privacy Act/FOIA

Date: __________________ Signature of Applicant: __________________

Date: __________________ General Assistance Caseworker: __________________
Landlord Statement

I understand that _______ has applied for General Assistance.

Client’s Name

As part of the application she/he must provide information about residence/shelter expenses. By this statement, I assert that I am landlord for _______ at the following address:

Client’s Name

Physical Address __________________________ City _______ State _______ Zip _______

I charge the following amount to the client:

Rent: Amount: $ ____________

Utilities: Amount: $ ____________

I understand that _______ will use this statement for the GA application.

Client’s Name

Landlord’s Signature __________________________ Address __________________________ Phone# __________________________
Authorization for Release of Information

I hereby authorize you to release any information from any medical facility, institutions, the Social Security Administration, any local, State, or Federal Law Enforcement Agency, or any other agency. The information will be used to prove my identity and moral standing in my respective community for the purposes of placement AND/OR adoption of foster children. I understand that this information is to be held confidential by all parties.

Name: ____________________________
Social Security #: __________________
Date of Birth: ______________________

The information is to be released from:

Name of Agency: ____________________
ATTN: ____________________________
Address: ____________________________
City/State: __________________________

The information is to be released to:

Name of Agency: ____________________
ATTN: ____________________________
Address: ____________________________
City/State: __________________________

The purpose of this information is: ______________________________________________________

____________________________________________________________________________________

Information to be released includes: ______________________________________________________

____________________________________________________________________________________

This authorization will terminate one year from the date of my signature. It is further understood that I may revoke this authorization any time by written request except to the extent that action has been taken in reliance thereon.

Signature: ____________________________ Date: ____________
Witness: ____________________________ Date: ____________
Department
Of
Social Services

CHEYENNE & ARAPAHO TRIBES
P.O. Box 38
Concho, OK 73022
Off: (405) 422-7476
Fax: (405) 422-8218

HEALTH EXAMINATION

(Last Name)  (First Name)  (MI)  (Gender)  (Age)

(Address)  (Tribe)

1. Patient’s Complaint: __________________________

2. Diagnosis (if laboratory reports, please indicate): __________________________

3. Interpretation of the diagnosis in relation to the way it affects the patient: Indicate any secondary physical, mental or personality difficulties which affect the Individual’s capacity to engage in the occupation he is prepared to do. Is the patient able to perform light duty/duty work: __________________________

4. Recommendations for treatment given to patient by physician __________________________

5. Is the condition temporary or permanent? __________________________

6. Is the patient employable? Yes _____ No _____

If employable, check maximum ability: Light manual labor _____ Heavy manual labor _____

Can patient be made employable (specify): __________________________

Date: __________________________ Signature of Provider: __________________________

Address: __________________________

*Note to assisting provider: Information gathered and contained herein is used to determine General Assistance Eligibility ONLY*
**Job Search Form**

To Whom It May Concern:

________________________ has applied for financial assistance through the Social Services Program with the Cheyenne-Arapaho Tribes. In order to determine eligibility for such assistance, we appreciate verification of the following information. Your signature certifies that this client has applied for employment at your company.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name:</td>
<td>Company Name:</td>
</tr>
<tr>
<td>Person Seen:</td>
<td>Person Seen:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone #:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name:</td>
<td>Company Name:</td>
</tr>
<tr>
<td>Person Seen:</td>
<td>Person Seen:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone #:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name:</td>
<td>Company Name:</td>
</tr>
<tr>
<td>Person Seen:</td>
<td>Person Seen:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone #:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

I swear that the information provided by me on this form is true.

Client Signature: __________________________ Date: __________________________

Caseworker Signature: __________________________ Date: __________________________
No Income Statement:
Please explain why you do not currently have an income, and also explain how your needs are currently being met.
I, ______________________, currently do not receive any monetary income because:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Client Signature:_________________________  Date:____________________

No Income Statement:
Please explain why you do not currently have an income, and also explain how your needs are currently being met.
I, ______________________, currently do not receive any monetary income because:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Client Signature:_________________________  Date:____________________

PLEASE NOTARIZE BELOW:

____________________________________
Signature of Client

SEAL

State of Oklahoma
County of ________________

Signed and/or attested before me on this _____day of ____________, 20__

______________________________  Commission#____________________
Notary Public  My Commission Expires:_________________
INDIVIDUAL SELF-SUFFICIENCY PLAN (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: ____________________________

BARRIER TO CLIENT
Limited Transportation ___
Limited Education ___
Limited/ No Work History ___
Limited/ No Jobs ___
No Job Skills ___
No driver’s license ___
Social Isolation ___
Criminal History ___
Homeless ___
Other ___

WORK ACTIVITIES
Job Search ___
Volunteer Work Experience ___
Job Sampling or Job Shadowing ___
On-the-Job Training ___
Employment Counseling ___
Registration with Local Job Service ___
Job Readiness ___
Other: ____________________________

STRENGTHS OF CLIENT (identify strengths the client possesses):

SELF-SUFFICIENCY PLAN & GOALS

_______ (Initial) I understand that the purpose of the individual Self-Sufficiency Plan (ISP) is to meet the goal of employment through specific actions steps and I am required to follow 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 I will contact my Caseworker in a timely manner to ensure my success in the General Assistance Program.

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

GA Recipient Signature: ____________________________ Date: __/__/____

General Assistance Caseworker: ____________________________ Date: __/__/____
General Assistance Checklist:

Case Name: __________________________

Address: ____________________________

In order for you General Assistance Application to be processed you must submit the following documents by [Date] or your application would be denied.

- Verification of residence (Recent rent receipt and one utility bill OR written statement from two uninterested parties verifying where you live)
- Verification of tribal enrollment (CDIB)
- Statement verifying whether or not you receive unemployment benefits
- Verification of all sources of income that you receive
- Verification of application of denial letter for TANF or SSI if potentially eligible
- Complete Job Search Form
- Complete Individual Self-Sufficiency Plan (ISP) with caseworker
- Verification of enrollment in GED/school/counseling/training classes (if required)
- Physician’s statement verifying that you are unable to work temporarily (if required)
- Other ____________________________

If you have any questions or need assistance please contact your General Assistance Caseworker at 405-422-7476.

General Assistance Caseworker: ________________________________

Date: _______________