MANIILAQ ASSOCIATION

Application for Services

If you need help filling out this form or have questions, please tell us — we can help!

Maniilaq Association Assistance Programs:

Maniilaq Tribal TANF

Provides monthly cash assistance to low income families with children to help them with basic needs while they work toward becoming self-sufficient. This program is designed to help needy families achieive self-sufficiency.

This application can also be used to apply for the following programs from the State of Alaska:

Food Stamps
Provides montly benefits to help people buy food or subsistence hunting and fishing equipment.

Medicaid/DenaliCare/DenaliKidCare
Offers medical coverage to families, children, elderly, disabled adults, and pregnant women. Also helps with Medicare Parts A and B premiums.

Chronic and Acute Medical Assistance
Helps people with specific illnesses who don't qualify for Denali Care and have little or no income.

Adult Public Assistance
Provides monthly cash payments and medical assistance to eligible elderly, blind, and disabled persons.

General Relief Assistance
Helps eligible individuals and families with emergency rent and utility needs. Also helps with burial costs.

— Information Page —

Read and keep this page for your records.

Please provide the following documents along with your application:

- ☐ Driver's license or state identification card (adults)
- ☐ Birth certificate (children under age 18)
- ☐ Proof of Tribal enrollment (all household members)
- ☐ Pay stubs or income statement (past 60 days)
- ☐ Paid bill receipts (past 60 days)
- ☐ Current bank statement
- ☐ Child support form (enclosed). Only if there is an absent parent, or for both the absent mother and father if applicable.
- ☐ Adults are required to apply for unemployment benefits or supply an unemployment denial letter (Unemployment: 1-888-252-2557).
- ☐ Proof of other types of assistance received such as General Assistance, Food Stamps, Medicaid and ATAP.

The Four Purposes of the TANF Program are:

1) To provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.

2) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage.

3) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies.

4) Encourage the formation and maintenance of two-parent families.

Your appointment is on:

Date/Day _____ Time _____ Phone _____

Location/Interviewer _____ Fax _____

Information Page — Keep this page for your records.

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor.

PARTICIPANT APPEAL

If you disagree with an action taken by the Maniilaq Tribal TANF program that affects the benefits, you may file a fair hearing request within 30 days of action. You may continue to receive Tribal TANF benefits until a Maniilaq agency appeal decision is made if you request in writing continuing cash assistance. If the appeal decision is not in your favor, you will be responsible to pay back any extra benefits you received while awaiting the appeal decision.

MANIILAQ CLIENT GRIEVANCE

A Grievance may be sought by any participant in a Maniilaq Association, Temporary Assistance to Needy Families program who believes that a violation of the act, the Regulations has occurred. The following procedure shall be used as the means of settling such grievances:

Step 1. The participant will first make his/her complaint known to his/her eligibility specialist, case worker, eligibility supervisor within 30 days of the incident.

Step 2. If the matter is not resolved to the satisfaction of the participant, the participant will immediately put such complaint in writing and submit this for review to the TANF Eligibility Supervisor, at P.O. Box 256 Kotzebue, Alaska 99752.

Step 3. If the matter is not resolved to the satisfaction of the participant, the participant will immediately request, in writing, to continue to Step 3. The complaint will then be reviewed by the Workforce Development Director.

Step 4. If the matter is not resolved to the satisfaction of the participant, the participant will immediately request, in writing, to continue to Step 4; a review by the Tribal Government Administrator.

Step 5. If the Tribal Government Administrator determination does not settle the matter to the grievant's satisfaction, the grievant may appeal to the State of Alaska, Department of Public Assistance. The participant will put their complaint in writing and submit it to Director, Department of Public Assistance, State of Alaska, P.O. Box 110640, Juneau, Alaska 99811-0640

CHANGES IN HOUSEHOLD CIRCUMSTANCES

You must report changes in your household within 10 days of when you learn of the change. You may do this by contacting the Maniilaq Tribal TANF office by phone, in person or in writing. You are required to report the following changes:

1. Changes in employment-starting or stopping a job, change in wage rate, change from part-time to full-time or full-time to part-time.
2. Changes in the source of unearned income and changes in the amount of total unearned income greater than $50.00 per month.
3. When someone moves into or out of your home or someone in your home has a baby (report within 5 days when a child leaves your home)
4. If you move or get a new mailing address; you need to verify your new shelter costs if you move or we cannot use them in calculating your benefits.
5. If your household gets a vehicle.
6. If your household has more than $2000 in cash and money in bank accounts.
7. Changes in your legal obligations to pay child support

WORK REQUIREMENTS

To receive Tribal Temporary Assistance benefits, you may have to participate in work activities. Tribal Temporary Assistance participants must prepare a family self-sufficiency plan that lists steps you will take to become financially independent. You must participate in approved work activities unless you qualify for an exemption. If you are an unmarried minor parent, to receive Tribal Temporary Assistance you must live with a parent or in another approved living arrangement and attend school or training. If you do not fulfill these work requirements or minor parent requirements your benefits may be reduced or ended.

HOME VISITS

A Maniilaq Tribal Temporary Assistance worker may visit your home and may contact other people to verify your eligibility for assistance for any or all of the following reasons: household composition, residence, and/or income and resources. If you do not cooperate with the home visit, your TANF case will be closed. A home visit may also be conducted if you are under a Tribal Temporary Assistance penalty. It is in your best interest to cooperate with a penalty home visit. If there is no cooperation, your assistance could be further reduced or ended. For these several types of home visits, no appointment will be set up with the participant ahead of time.

COMPUTER MATCHING AND YOUR SOCIAL SECURITY NUMBER

Your Social Security Number may be used to obtain information from various state and federal agencies through computer matching. This information may be used to determine your eligibility. You are not required to provide a Social Security number or citizenship information for anyone in the household who will not be on the TANF grant.

FRAUD PENALTY WARNINGS

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get Tribal Temporary Assistance benefits you are not eligible for, or to help someone else get benefits for which they are not eligible. You must repay any benefit you wrongly receive.

WARNING: Any information you provide to Maniilaq Tribal TANF Program may be used against you in a Court of Law or for implementing an Administrative Disqualification Hearing which will result in an Intentional Program Violation disqualification from Tribal TANF.

If you misrepresent your residence or identity to receive multiple benefits, you can be barred from receiving Tribal Temporary Assistance for 10 years.

Other penalties may also apply.

POST TRIBAL TANF SERVICES

If your Tribal TANF case closes because of earnings, you may still be eligible for other services to help your family move from welfare to work. Tribal TANF recipients may get child care assistance and caseworker support when their case closes for earnings, please contact the Maniilaq Tribal TANF office for more information.

You may also be eligible for additional services offered by the State of Alaska Division of Public Assistance such as Food Stamps and Medicaid, please contact your case manager or nearest Division of Public Assistance Office for more information.

CHILD SUPPORT INFORMATION AND COOPERATION

Alaska must collect child support and medical support from any parent who has the duty to pay support to a Tribal Temporary Assistance recipient. This includes any money owed to you at the time you apply, as well as current and future child support payments.

Any child support payments given or paid to you while receiving Tribal Temporary Assistance benefits must be reported and turned over to the Maniilaq Tribal Temporary Assistance Program immediately. If you wish to change a child support order, you must obtain a new court order or get permission from the State of Alaska Child Support Services Division (CSSD).

Note: If you believe you have a good reason not to cooperate with CSSD for the Tribal Temporary Assistance program, you must tell your caseworker immediately. You may be asked to provide information to support your reason.

When you apply for Tribal Temporary Assistance you must:

- Sign over to the Maniilaq Tribal Temporary Assistance Program your right to receive and keep child support payments due to you or to a child on Tribal Temporary Assistance.
- Cooperate with the Child Support Services Division (CSSD) by providing information to establish paternity, help locate an absent parent, and enforce a child support obligation.

AMERICANS WITH DISABILITIES ACT OF 1990

Maniilaq Health Center complies with Title II of the Americans with Disabilities Act of 1990.

SOCIAL SECURITY NUMBERS

You must provide or apply for a social security number for yourself and each household member for whom you are seeking benefits from the Maniilaq Tribal Temporary Assistance program (42 CFR 435.910).

OVERPAYMENT

If at any time you receive TANF funds for which you are not eligible for due to not reporting income/household composition etc. you will be required to repay Maniilaq TANF.

I certify that I have read and understand the entirety of this document.

_____ _____

Signature of Participant/ Date Signature of Other Adult/ Date

Notes

What happens if I do not follow the rules?

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get public assistance benefits you are not eligible for, or to help someone get benefits for which they are not eligible. You must repay any benefits you wrongly receive.

Manilaq Tribal TANF Program

I understand that if I...	I may...
• commit an intentional program violation or I am convicted of fraud • give false information about who I am and where I live so I can get extra benefits	• lose benefits for 6 months for the first offense • lose benefits for 12 months for the second offense • lose benefits permanently for the third offense • other penalties may also apply and I may be subject to criminal prosecution • have to pay back amount received if there is an overpayment

Food Stamp Program

I understand that if I...	I may...
Commit an intentional program violation of the Food Stamp Program defined in 7 CFR 273.16 or any of the following: • hide information or make false statements • use electronic benefit transfer (EBT) cards that belong to someone else • use food stamp benefits to buy alcohol or tobacco • trade or sell benefits or EBT cards	• lose food stamp benefits for 12 months for the first offense and be required to repay all benefits overpaid to me • lose food stamp benefits for 24 months for the second offense and be required to repay all benefits overpaid to me • lose food stamp benefits permanently for third offense and be required to repay all benefits overpaid to me • be fined up to $250,000.00, imprisoned up to 20 years or both
• trade food stamp benefits for controlled substances, such as drugs	• lose food stamp benefits for 24 months for the first • offense • lose food stamp benefits permanently for the second offense
• give false information about who I am and where I live so I can get extra benefits	• lose food stamp benefits for 10 years for each offense
• have been convicted of trading or selling food stamps worth more than $500, or trading food stamps for firearms, ammunition, or explosives	• be barred from the Food Stamp Program permanently

Denali Care Program

I understand that if I...	I may...
• commit an intentional program violation or program abuse that results in misuse or overuse of Denali Care benefits or are found guilty of misconduct related to Medicaid benefits • commit Medical Assistance fraud under AS 47.05.210	• be required to pay back the amount of Denali Care services that I or anyone in my household received • be excluded from Denali Care for up to 10 years • have to pay fines up to $25,000 and be subject to criminal prosecution

Read and keep this page.

MANIILAQ ASSOCIATION

Tribal TANF Date Received/Signature

Date Received

Application for Services

What kind of help do you need? Check the programs or services you need.

☐ **Maniilaq Tribal TANF**

Provides monthly cash assistance to low income families with children to help them with basic needs while they work toward becoming self-sufficient. This program is designed to help needy families achieve self-sufficiency.

Assistance programs from the State of Alaska:

☐ **Food Stamps**

Provides monthly benefits to assist with food costs or subsistance hunting/fishing equipment.

Important:

You may be eligible for food stamps within seven days - answer the questions at the bottom of this page.

☐ **Health Insurance**

Including Medicaid, Denali Care, Denali KidCare, Chronic & Acute Medical Assistance, tax credit & private health insurance.

☐ **Adult Public Assistance**

Provides a monthly cash payment and medical assistance to eligible elderly, blind, and disabled persons.

- ☐ blind or disabled
- ☐ elderly assistance

☐ **General Relief Assistance**

Emergency assistance for eligible individuals and families.

- ☐ rent or utilities
- ☐ burial expenses

Answer these questions to see if you can get Food Stamps within seven days:

Do you have more than $100 in cash or money in the bank?	☐ Yes ☐ No
Is your household's monthly gross income (before deductions) less than $150?	☐ Yes ☐ No
Are your costs for rent/mortgage/utilities more than your monthly gross income, cash and money in the bank?	☐ Yes ☐ No

Who are you? (Please print)

1. First name, Middle name, Last name, & Suffix

Other Names (maiden, nicknames, etc.)

2. Home address or directions to your house

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Mailing address (if different from home address)

8. Apartment or suite number

9. City

10. State

11. ZIP code

12. Phone number

( ) –

13. Other phone number

( ) –

14. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address:

15. What is your preferred spoken or written language (if not English)?

16 -18.

Tell us about yourself and the people living in your home.

Household Members (Enter name)	Relation (NR = Not Related	Birth Date	Social Security Number *If applying for assistance*	Sex (M/F)	Education (Last Grade Completed - GED, College)	Race	Ethnic Group
						Optional - Use codes below	
Example: Joe Smith	Self	2/10/74	xxx-xx-xxxx	M	12th	WH	N

Race: (You may select more than one race)

AN = Alaskan Native **WH** = White **BL** = Black or African American

AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander

Ethnicity:

Y = Hispanic or Latino
N = Not Hispanic or Latino

People in your household

Complete for each person in your household.

Start with yourself, and then add others. For more than four people, make a copy of the blank pages and attach. Family members who don't need health coverage or public assistance don't need to provide immigration status or a Social Security number.

19. First name, Middle name, Last name, & Suffix

20. Relationship to you?
Self

21. Social Security number
___ ___ ___ - ___ - ___ ___ ___ ___

22. Date of birth (mm/dd/yyyy)

23. Sex ☐ Male ☐ Female

We need your Social Security Number (SSN) if you want health coverage or public assistance. If you need a SSN, call 1-800-772-1213 or visit *socialsecurity.gov*. TTY users, call 1-800-325-0778.

24. Do you plan to file a federal income tax return NEXT YEAR? You can apply for health insurance even if you don't file a tax return.
☐ Yes.
☐ No. Skip to question C

a. Will you file jointly with a spouse? ☐ Yes ☐ No
Name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
List name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
List the name of the tax filer: _____ Relation to tax filer? _____

25. Are you pregnant? ☐ Yes ☐ No How many babies expected this pregnancy? _____ Due date: _____

26. Do you need health coverage or public assistance services for yourself? Even if you have insurance there might be a program with better coverage or lower cost.
☐ Yes.
☐ No. Skip questions 27-36.

27. Do you have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? ☐ Yes ☐ No

28. Are you a U.S. citizen or U.S national? ☐ Yes ☐ No

29. If you aren't a U.S. citizen or national, do you have eligible immigration status? ☐ Yes ☐ No
Fill in your document type and ID number below.

a. Immigration document type: _____ Document ID number: _____

b. Have you lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

c. Are you, your spouse, or parent a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

30. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

31. Do you have medical costs due to an accident? ☐ Yes ☐ No

32. Do you live with a child under age 19, for whom you are the primary caretaker? ☐ Yes ☐ No

33. Are you a full-time student? ☐ Yes ☐ No

34. Were you in foster care at age 18 or older? ☐ Yes ☐ No

35. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

36. Race (OPTIONAL—check all that apply.)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Alaska Native	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

PERSON 2 People in your household.

Answer the questions for the next person in your household.

37. First name, Middle name, Last name, & Suffix

38. Relationship to you?

39. Social Security number

__ __ __ - __ - __ __ __ __

40. Date of birth (mm/dd/yyyy)

41. Sex ☐ Male ☐ Female

We need this person's Social Security Number (SSN) if they want health coverage or public assistance. If they need a SSN, call 1-800-772-1213 or visit *socialsecurity.gov*. TTY users, call 1-800-325-0778.

42. Does this person plan to file a federal income tax return NEXT YEAR? They can apply for health insurance even if they don't file a tax return.
☐ Yes.
☐ No. Skip to question C

a. Will this person file jointly with a spouse? ☐ Yes ☐ No
Name of spouse: _____

b. Will this person claim any dependents on their tax return? ☐ Yes ☐ No
List name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
List the name of the tax filer: _____ Relation to tax filer? _____

43. Is this person pregnant? ☐ Yes ☐ No How many babies expected this pregnancy? _____ Due date: _____

44. Does this person need health coverage or public assistance services? Even if they have insurance there might be a program with better coverage or lower cost.
☐ Yes.
☐ No. Skip questions 45-54.

45. Does this person have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? ☐ Yes ☐ No

46. Is this person a U.S. citizen or U.S national? ☐ Yes ☐ No

47. If this person is not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes ☐ No
Fill in their document type and ID number below.
a. Immigration document type: _____ Document ID number: _____
b. Has this person lived in the U.S. since August 22nd, 1996? ☐ Yes ☐ No
c. Is this person, their spouse, or parent a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

48. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

49. Does this person have medical costs due to an accident? ☐ Yes ☐ No

50. Does this person live with a child under age 19, for whom they are the primary caretaker? ☐ Yes ☐ No

51. Is this person a full-time student? ☐ Yes ☐ No

52. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

53. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

54. Race (OPTIONAL—check all that apply.)
☐ White
☐ Black or African American
☐ Alaska Native
☐ American Indian
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

PERSON 3 People in your household.

Answer the questions for the next person in your household.

55. First name, Middle name, Last name, & Suffix

56. Relationship to you?

57. Social Security number
__ __ __ - - __ __ __ __

58. Date of birth (mm/dd/yyyy)

59. Sex ☐ Male ☐ Female

We need this person's Social Security Number (SSN) if they want health coverage or public assistance. If they need a SSN, call 1-800-772-1213 or visit *socialsecurity.gov*. TTY users, call 1-800-325-0778.

60. Does this person plan to file a federal income tax return NEXT YEAR? They can apply for health insurance even if they don't file a tax return.
☐ Yes.
☐ No. Skip to question C

a. Will this person file jointly with a spouse? ☐ Yes ☐ No
Name of spouse: _____

b. Will this person claim any dependents on their tax return? ☐ Yes ☐ No
List name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
List the name of the tax filer: _____ Relation to tax filer? _____

61. Is this person pregnant? ☐ Yes ☐ No How many babies expected this pregnancy? _____ Due date:

62. Does this person need health coverage or public assistance services? Even if they have insurance there might be a program with better coverage or lower cost.
☐ Yes.
☐ No. Skip questions 63-72.

63. Does this person have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? ☐ Yes ☐ No

64. Is this person a U.S. citizen or U.S national? ☐ Yes ☐ No

65. If this person is not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes ☐ No
Fill in their document type and ID number below.

a. Immigration document type: _____ Document ID number: _____

b. Has this person lived in the U.S. since August 22nd, 1996? ☐ Yes ☐ No

c. Is this person, their spouse, or parent a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

66. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

67. Does this person have medical costs due to an accident? ☐ Yes ☐ No

68. Does this person live with a child under age 19, for whom they are the primary caretaker? ☐ Yes ☐ No

69. Is this person a full-time student? ☐ Yes ☐ No

70. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

71. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

72. Race (OPTIONAL—check all that apply.)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Alaska Native	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

PERSON 4 People in your household.

Answer the questions for the next person in your household.

73. First name, Middle name, Last name, & Suffix

74. Relationship to you?

75. Social Security number ___ ___ ___ - - ___ ___ ___ ___

76. Date of birth (mm/dd/yyyy)

77. Sex ☐ Male ☐ Female

We need this person's Social Security Number (SSN) if they want health coverage or public assistance. If they need a SSN, call 1-800-772-1213 or visit *socialsecurity.gov*. TTY users, call 1-800-325-0778.

78. Does this person plan to file a federal income tax return NEXT YEAR? They can apply for health insurance even if they don't file a tax return.
☐ Yes.
☐ No. Skip to question C

a. Will this person file jointly with a spouse? ☐ Yes ☐ No
Name of spouse: _____

b. Will this person claim any dependents on their tax return? ☐ Yes ☐ No
List name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
List the name of the tax filer: _____ Relation to tax filer? _____

79. Is this person pregnant? ☐ Yes ☐ No How many babies expected this pregnancy? _____ Due date:

80. Does this person need health coverage or public assistance services? Even if they have insurance there might be a program with better coverage or lower cost.
☐ Yes.
☐ No. Skip questions 81-90.

81. Does this person have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? ☐ Yes ☐ No

82. Is this person a U.S. citizen or U.S national? ☐ Yes ☐ No

83. If this person is not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes ☐ No
Fill in their document type and ID number below.

a. Immigration document type: _____ Document ID number: _____

b. Has this person lived in the U.S. since August 22nd, 1996? ☐ Yes ☐ No

c. Is this person, their spouse, or parent a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

84. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

85. Does this person have medical costs due to an accident? ☐ Yes ☐ No

86. Does this person live with a child under age 19, for whom they are the primary caretaker? ☐ Yes ☐ No

87. Is this person a full-time student? ☐ Yes ☐ No

88. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

89. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

90. Race (OPTIONAL—check all that apply.)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Alaska Native	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

STEP 3 Income in your household

If you need more space, attach another sheet of paper providing all information asked below. Tell us about your income.

JOB 1

91. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other	

JOB 2

92. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other	

JOB 3

93. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other	

JOB 4

94. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other	

Please answer the following questions about income.

95. For self-employed household members, please answer the following questions (if you have more jobs and need more space, attach another sheet of paper).

a. Include money from all self-employment jobs received this month or that will be received next month. Please check all boxes that apply.

☐ B&B/Rent Rooms	☐ Crafts/Carving	☐ Odd Jobs	☐ Taxi Driving
☐ Carpenter	☐ Commercial Fishing	☐ Repair Person	☐ Trapping
☐ Child Care/Babysitting	☐ Manage Rental Property	☐ Sales Person	☐ Other

For all the items checked on part a, please fill in the boxes below:

Household Member Who is Self-Employed	Type of Business	Seasonal, Year-round	Business Income This Month	Business Income Next Month	Business Expenses This Month	Business Expenses Next Month
Example: Joe Smith	Fishing	Seasonal	$900	$900	$100	$100

96. In the past 2 months, did anyone in the household: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Name (s): _____

97. OTHER INCOME: Check all that apply, and give person name, amount received, and how often it is received.

NOTE: For Health Insurance only applications, you don't need to tell us about child support, Veteran's payment or Supplemental Security Income (SSI).

☐ None	☐ Net Rental/Royalty	☐ Net Fishing/Farming
☐ Alimony	☐ Pension/Retirement Benefits	☐ Social Security Benefits
☐ Child Support	☐ Supplemental Security Income	☐ Unemployment Benefits
☐ Unemployment Benefits	☐ Veteran's Benefits	☐ Other _____

For all the items checked above, please fill in the boxes below:

Who Receives the Payment?	Type of Payment	Amount This Month	Amount Expected Next Month	How Often?
Example: Joe Smith	Unemployment	$400	$400	Every 2 weeks

98. DEDUCTIONS: Check all that apply, and give person name, amount received, and how often it is received.

If a household member pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answers to net self-employment (question 29).

☐ Alimony Name(s)_____ $_____ How often?_____

☐ Student loan interest Name(s)_____ $_____ How often?_____

☐ Other deductions Name(s)_____ $_____ How often?_____

Type:

99. YEARLY INCOME: Complete only if the income you listed changes from month to month.

Name of person(s)_____ Total income this year $_____ Next year (if different) $ _____

Name of person(s)_____ Total income this year $_____ Next year (if different) $ _____

100. Does any person applying for health insurance or public assistance services expect any changes in any of their income or employment (new income or employment not provided)? ☐ Yes ☐ No

If yes, please explain:_____

STEP 4 Alaska Native or American Indian (AN/AI) family members

101. Are you or is anyone in your family Alaska Native or American Indian?

☐ No, skip to Step 5. ☐ Yes, please complete Appendix B.

STEP 5 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

102. Is anyone enrolled in health coverage from the following: ☐ Yes ☐ No

Check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Denali Care _____ ☐ Employer insurance _____

☐ Denali KidCare _____ ☐ Name of health insurance _____

☐ Medicare _____ ☐ Policy number: _____

☐ TRICARE (don't check if you have direct care or line of duty) Is this COBRA coverage? ☐ Yes ☐ No

Is this retiree health plan? ☐ Yes ☐ No

☐ Other: Name of insured:_____ ☐ Peace Corps _____

Policy number: _____ ☐ VA health care

Name of health insurance:_____ Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

103. Is anyone listed on this application offered health coverage from a job? Check yes, even if the coverage is from someone else's job, such as a parent or spouse.

☐ Yes. Please complete and include Appendix A.
☐ No.

STEP 7 Assets, Expenses, Resources, and Other

If you need more space, attach another sheet of paper providing all information asked below.

104. Does any person applying for health insurance or other public assistance services own any property such as a house, land, apartment, mobile home, duplex, condo, camper or cabin? ☐ Yes ☐ No

If yes, complete the information below. Include any property that is paid for, you are still paying for, or that is owned with someone else.

Who Owns the Property?	Type of Property Owned	Estimated Value	Amount Owed
Example: Joe Smith	Condo	$75,000	$70,000

105. Do you, or anyone who lives with you, own any vehicles such as a car, truck, motorcycle, boat, snowmobile, personal watercraft, aircraft, recreational vehicle (RV) or all-terrain vehicle (ATV)? ☐ Yes ☐ No

Please complete the information below. Include any vehicles that are paid for, you are paying for, or are owned with someone else. Also include vehicles that are not running or that you are not using.

Who Owns the Vehicle?	Vehicle Type, Model and Year	What is Vehicle Used for?	Estimated Value	Amount Still Owed
Example: Joe Smith	1987 Ford Escort	Work	$800	$200

106. Do you, or anyone who lives with you, have any of the items below? ☐ Yes ☐ No

Check the boxes that apply. Include items owned with someone else and accounts with no money in them right now.

- ☐ Annuities
- ☐ Burial Policy Agreement
- ☐ Cash on Hand
- ☐ Certificate of Deposit
- ☐ Checking Account
- ☐ College Savings Plan
- ☐ Credit Union Accounts
- ☐ Commercial Fishing Permit
- ☐ IRA Account
- ☐ Life Insurance Policy
- ☐ Mineral Rights
- ☐ Native Corporation Shares
- ☐ Pension Plan
- ☐ Retirement Funds
- ☐ Safe Deposit Box
- ☐ Savings Account
- ☐ Stocks/Bonds
- ☐ Trust Funds
- ☐ Other _____

107. For all items checked above, please fill in the boxes below:

Who Owns the Item?	Type of Item	Where Held?	Account Number	Total Value/ Balance
Example: Jane Smith	Checking Account	Frontier Bank	452231	$300

108. Have you, or anyone in your household, sold, given away, or transferred any property, vehicles or other resources in the past five years? ☐ Yes, please complete the information below. ☐ No

Who Owned It?	Vehicle, Property, or Resource	Sold, Gave Away, or Transferred?	When?	Estimated Value
Example: Joe Smith	Truck	Gave Away	May 2005	$4,000

109. What are your shelter expenses? Check the boxes that apply and fill in the amount that you are required to pay.
Do not enter amounts paid by housing assistance such as HUD, ASHA, AHFC or Section 8.

☐ Rent $_____per month ☐ Mobile Home Lot or Space Rent $_____per month

☐ Mortgage $_____per month

110. What shelter expenses are billed separately from your rent or mortgage?

☐ Home/Renters Insurance $_____per _____ ☐ Property Taxes $_____per _____

☐ Condo/Association Fees $_____per _____ ☐ Other (such as deposits) $_____per _____

111. Check the boxes next to the utility bills your household is responsible for paying monthly:

☐ Heat (such as gas, electric, propane, wood, etc.) $_____ ☐ Sewer $_____ ☐ Telephone $_____

☐ Water $_____ ☐ Electricity $_____ ☐ Garbage $_____ ☐ Other $_____

112. Does your household receive LIHEAP or does your household expect to receive LIHEAP ? ☐ Yes ☐ No

113. Does any person work for or get help with food, shelter, utilities, or other expenses that are not paid in cash? ☐ Yes ☐ No

Please explain: _____

114. Does a person or agency help pay all or part of your shelter costs (like housing or heating assistance)? ☐ Yes ☐ No

Who pays?_____What expense?_____Amount paid?_____

115. Does anyone in your household have child care, elderly or disabled adult care expenses? ☐ Yes ☐ No

Who is responsible for paying?_____

Who is it for?_____Monthly Amount $_____

116. Does anyone in your household pay child support? ☐ Yes ☐ No

Who pays?_____Monthly Amount $_____

117. Does anyone in your household who is disabled or age 60 or older, have medical expenses? ☐ Yes ☐ No

Who has the expense?_____Monthly Amount $_____

118. Has anyone in your household received public assistance (Temporary Assistance, cash, food stamps, Medicaid, Food Distribution Program on Indian Reservations FDPIR) in Alaska or any other state? ☐ Yes ☐ No

If yes, who, when and where?_____

Felony Convictions

119. Has anyone been convicted of any of the following types of felonies? ☐ Yes ☐ No

☐ Drug-related felony? Date of conviction:_____Who and where?_____

☐ Making a false statement about where you live in order to receive assistance from two or more states at the same time.

Date of conviction:_____Who and where?_____

120. Is any adult in your household fleeing from prosecution, custody, confinement for a felony or class A misdemeanor from any state? If yes, who? _____ ☐ Yes ☐ No

121. Have you or any member of your household been convicted of trading Food Stamp benefits for drugs after September 22, 1996? If yes, who and when?_____ ☐ Yes ☐ No

122. Have you or any member of your household been convicted of buying or selling Food Stamp benefits over $500 after September 22, 1996? If yes, who and when?_____ ☐ Yes ☐ No

123. Have you or any member of your household been convicted of fraudulently receiving duplicate Food Stamp benefits in any State after September 22, 1996? If yes, who and when?_____ ☐ Yes ☐ No

124. Have you or any member of your household been convicted of trading Food Stamp benefits for guns, ammunitions, or explosives after September 22, 1996? If yes, who and when?_____ ☐ Yes ☐ No

Do you live in areas where getting to food stores is difficult and often rely on subsistence hunting and fishing for your food needs? If you are in this situation, you may use food stamp benefits to buy subsistence hunting and fishing items. These items include nets, lines, hooks, fishing rods, harpoons, and knives, but not firearms, ammunition, clothing, shelter, or fuel. Do you want to use food stamps to buy subsistence hunting and fishing items? ☐ Yes ☐ No

If yes, sign here: _____

Signature of Adult Household Member Date

STEP 8 Release of Information

Your signature gives the Maniilaq Area Native Association, Department of Health and Social Services, its agents, and the Department of Law permission to ask for information about your health, finances, family and personal history. This information is only used in the administration of the Maniilaq Area Native Association's Tribal TANF Program and public assistance programs and will not be released to any other person or agency outside of the Federally Facilitated Marketplace, Department of Health and Social Services or its representatives except as required by law. The Release of Information will be in effect while you are an applicant or recipient of Public Assistance, and for any later investigations of your eligibility and receipt of benefits.

We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof. We may also contact other people or organizations including, but are not limited to: the Alaska Housing Finance Corporation, the Department of Fish and Game, the Department of Labor, the Department of Law, the Department of Military and Veterans Affairs, the Department of Public Safety, the Department of Revenue, U. S. Citizenship and Immigration Services, employers, financial institutions, landlords, local governments, Native corporations, private individuals, public assistance program contractors and grantees, school authorities, the Social Security Administration, stock brokerage firms, and tax assessors. We need this information to check your eligibility for Tribal TANF and public assistance services and to check your eligibility for help paying for health coverage if you choose to apply.

For persons who will receive health care authorized by the Federally Facilitated Marketplace:

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: ☐ 5 years (max allowed) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use tax return information to renew my coverage.

If anyone on this application is eligible for Denali Care:

- I am giving the State Denali Care agency the rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Denali Care agency rights to pursue and get medical support from a spouse or parent.
- I know that I must tell the Health Insurance Marketplace and or the Public Assistance office by phone, in person or in writing if anything changes and if anything is different than what I wrote on this application I understand that a change in my information could affect the eligibility for the member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting *www.hhs.gov/ocr/office/file*.

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

- If yes, I know I will be asked to cooperate with the agency that collects medical and temporary assistance support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Maniilaq Tribal TANF Program or the Division of Public Assistance and I may not have to cooperate. Please see Appendix D.

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

If this is incorrect, who is incarcerated?_____

The person who filled out step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required in Appendix C.

Printed Name of Applicant: _____

Printed Name of Applicant: _____

Sign this application: _____ _____

Signature Date (month/day/year)

Sign this application: _____ _____

Signature Date (month/day/year)

STEP 9 Statement of Truth

Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge.

I have read or heard read to me the “Rights and Responsibilities” section of the application and I understand my rights and responsibilities, including fraud penalties, as described in this application.

Printed Name of Applicant: _____

Printed Name of Applicant: _____

Signature of Adult Applicant: _____

Signature Date (month/day/year)

Signature of Other Adult Applicant: _____

Signature Date (month/day/year)

Signature of Witness, if signed with an ‘X’: _____

Signature Date (month/day/year)

STEP 10 Contact People and Organizations

Why do you need to complete this form?

To determine your eligibility for assistance, we may need to contact people or organizations that can answer questions about your situation. By completing this form, you are allowing us to contact the people and organizations you provide.

What questions do we ask?

We often ask questions about where you live, who lives with you, and your household's income and resources. We may also ask for information about a child's parent not living in the home.

What information do we provide them?

When we contact these people or organizations, we tell them our name and title. We also tell them that we work for the Maniilaq Area Native Association's Tribal TANF Program. We do not give them any information about you or your public assistance services.

Information about two people who know you well:

Name and Relation to You	Mailing Address	Daytime Phone

Information about your landlord:

Name	Mailing Address	Daytime Phone

Appendix A: Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____-_____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name:_____ Name:_____ Name: _____

☐ No

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Appendix A: Employer Coverage Tool

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number _____-_____-_____

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) _____-_____
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your application for services.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Denali Care or the Children's Health Insurance Program (DKC). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code

7. Phone number
( ) –

8. Organization name	9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name	4. ID number (if applicable)

APPENDIX D: Child Support Information

APPENDIX D: CHILD SUPPORT INFORMATION PLEASE PRINT IN INK.

Complete a form for each noncustodial parent. The information will be used to establish and/or enforce child support.

Your name:_____ Your SSN: _____

Address:_____ City/State/Zip: _____

Phone:_____ Email:_____ Driver's License: State_No._____

Your relationship to children: ☐ Father ☐ Mother ☐ Other (explain)_____

Non-custodial parent's full legal name:_____ and their SSN: _____

Child's Full Name	Date of birth	Place of birth (city, county, state)	Child's SSN	Absent Parent Full name	Are both parents on birth certification?
					Yes No
					Yes No
					Yes No

Non-custodial parents: Date of birth:_____ Place of birth: _____

Address:_____ City/State/Zip:_____

Non-custodial parent's usual occupation, current employer and location: _____

_____ Does the non-custodial parent have medical insurance for the children?

_____ Type/Policy:__ Union member?__ Tribe or Native Corporation member?__

☐ Married:_____ Date:_____ Where:_____

☐ Married and Separated: _____ Date of separation:_____ Where: _____

☐ Divorce pending:_____ Date filed and what court: _____

☐ Divorced:_____ Date final:_____ Where:_____

☐ Never married: If the parents never married, has paternity been established by court or administrative order for each child listed?

☐ Yes ☐ No If no, please explain:_____

Is there a custody order regarding the children? ☐ Yes ☐ No If yes, provide the following information about the order:

State/County:_____ Court/Agency:_____ Date: _____

Do you have a child support order: ☐ Yes ☐ No If yes, provide the following information about the order:

State/County:_____ Court/Agency:_____ Date: _____

CHILD SUPPORT COOPERATION AND ASSIGNMENT OF SUPPORT

You are required by law to help get child support for a child receiving Tribal TANF payments or medical support for a child receiving medical assistance (Medicaid). This means you must help locate a non-custodial parent or establish paternity for a child with no legal father. You must sign over to the State agency any child/spousal support or medical support owed to you for any month you receive assistance. If the non-custodial parent pays support payments to you while you are receiving Temporary Assistance, you must turn the payments over to Child Support Services Division (CSSD). You must do this even if no support order in effect.

☐ If CSSD sends a payment to you in error, they will contact you for repayment of that money. If you want to repay gradually out of future child support payments, instead of immediately in a lump sum, check this box.

SUPPLYING INFORMATION TO CSSD – CONFIDENTIALITY AND SAFETY

If you believe that cooperating with CSSD to get child or medical support will bring harm to you or your children and you can provide support for your belief, you may claim good cause for not cooperating. You will be asked by a Public Assistance caseworker to complete "good cause" claim forms. It is up to the caseworker to decide if you have good cause for not cooperating. CSSD will continue to pursue child or medical support against the non-custodial parent, even if you DO NOT cooperate, unless the Division of Public Assistance approves good cause. Please check one of the boxes and sign below.

☐ I agree to cooperate with CSSD.
☐ I agree to cooperate with CSSD but I want my address kept confidential.
☐ I believe I have good cause to not cooperate with CSSD.

Signature_____ Date_____