

CRITERIA FOR DEVELOPING A FEDERAL GENERAL ASSISTANCE APPLICATION

The Federal G. A. Application you have submitted is in the status checked below.

- COMPLETE** AS OF _____
- INCOMPLETE** (Please submit the following items that are checked. Your application will not be processed until complete. **Incomplete application is kept on file for 30 days!**)
- 1. (A) Register with the state employment services (**Need Written Documentation**)
(B) Documentation that you applied for unemployment benefits
(C) Wages History Summary (past 3 months)
 - 2. Get **6 work search** forms filled out from prospective employers. (At least 4 must be from non-Indian Employers).
 - 3. Apply with **Employment & Training Program (Citizen Potawatomi Nation)**
 - 4. Apply for **TANF** (must turn in letter from DHS office)
 - 5. Apply for **Food Stamps** or **Commodities** (need letter from DHS/Commodity program, if already receiving, need copy of card and award letter)
 - 6. **Proof of residency** (Copy of current utility bill in your name, if living with someone else, need statement of support form from the person you are living with and copy of their current bill)
 - 7. Enroll in and attend GED classes (need written documentation of enrollment and attendance from instructor)
 - 8. Proper **Medial Documentation** (need doctor statements stating the period of time that you are unable to work and why)
 - 9. Apply for **Social Security/SSI (disability)** and letter from the Social Security office.
 - 10. Attend alcohol/parenting skills meeting on a regular basis (need letter from counselor)
 - 11. Copies of **CDIB** cards, Drivers License, Social Security cards, Birth Certificates
 - 12. (A) Copy of court custody/Divorce decree for the children of single parent
(B) Copy of court guardianship if applicant is not the natural parent

Participant Signature

Date

Social Services Representative

Date

FEDERAL GENERAL ASSISTANCE DEVELOPMENT PLAN

NAME: _____

DATE: _____

ASSESSMENT OF NEED:

- Public Assistance Recipient
- Lacks Transportation
- Homeless
- Substance Abuse
- Pregnant/Parenting Youth

- Limited English
- Limited Work History
- Disabled
- Children under 18
- Criminal Violations

	BARRIERS	ASSETS	GOALS
EDUCATION			
EMPLOYMENT			
OTHER (disabilities, work history, criminal violations)			

CERTIFIED STATEMENT: I am in agreement with the assessment and goals and will commit myself to achieve these objectives. I also understand that the above information will be treated in a confidential manner.

Participant

Date

Social Services Representative

Date

**U.S. DEPARTMENT OF THE INTERIOR BUREAU OF INDIAN AFFAIRS
SOCIAL SERVICES APPLICATION FOR ASSISTANCE SERVICES**

NAME: _____

PHONE #: _____

ADDRESS: _____

FAMILY PROFILE

Family Size: _____

MEMBERS OF HOUSEHOLD	BIRTHDATE			SEX	RELATION TO APPLICANT	S.S. NUMBER	TRIBE
	MO.	DAY	YR.				
1.					SELF		
2.							
3.							
4.							
5.							
6.							
7.							
8.							

RECORD OF INCOME AND RESOURCES

Earned: _____

General Assistance: _____

Unearned: _____

Child Welfare: _____

Total Monthly Income: _____

Total State Income: _____

Monthly Amount Needed: _____

Terminated from TANF in past 90 days? Yes No

Eligible to reapply for TANF? Yes No

**U.S. DEPARTMENT OF THE INTERIOR BUREAU OF INDIAN AFFAIRS
SOCIAL SERVICES APPLICATION FOR ASSISTANCE SERVICES**

NAME: _____

DECISION

APPROVED DENIED DATE: _____

Review Dates: _____

Social Services Representative

Date

STATEMENT OF COOPERATION

I apply for financial assistance for services for the listed members of my household who are in need. I have received a copy of and have had explained to me, and understand the provisions of Federal Law governing fraud. I agree to supply information regarding resources and income and to notify the agency of any changes in my situation. Social Services is authorized to obtain information necessary to establish eligibility for assistance. I have read, or had explained to me, the provision of our protection under Privacy Act.

Applicant Signature

Date

Co-Applicant Signature (if any)

Date

Social Services Representative

Date

**ABSENTEE SHAWNEE TRIBE OF OKLAHOMA
SOCIAL SERVICES CASE PLAN**

Last	First	Middle
------	-------	--------

Birthday	Social Security No.	Phone No.
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Street Address	City	State	Zip
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Physical/Mental Health:

Living Arrangements:

Narrative, Justification and Case Plan:

Persons present at Case Planning:

Participant Signature

Date

Social Services Representative

Date

ABSENTEE SHAWNEE TRIBE OF OKLAHOMA SOCIAL SERVICES
CONSENT TO RELEASE OF INFORMATION

TO: _____ RE: _____
_____ SS#: _____
_____ DOB: _____

You are hereby requesting and authorized to release information from your records to:

Absentee Shawnee Tribe of Oklahoma
Social Services Department
2025 S. Gordon Cooper Dr.
Shawnee, OK 74801

Participant Signature Date

Social Services Representative Date

Witness (only if signature is by mark) Date

GOOD FOR ONE YEAR FROM DATE OF SIGNATURE

ABSENTEE SHAWNEE TRIBE OF OKLAHOMA SOCIAL SERVICES
CONSENT TO RELEASE OF INFORMATION

All Accounts
Bureau of Indian Affairs
P.O. Box 368
Anadarko, OK 73005

RE: _____ SS#: _____

DOB: _____

You are hereby requested and authorized to release information from your records to:

Absentee Shawnee Tribe of Oklahoma
Social Services Department
2025 S. Gordon Cooper Dr.
Shawnee, OK 74801

This information is to used to determine eligibility for federal general assistance. Does _____ receive any kind of oil/gas or farming/grazing lease income? If so, please mail a copy of his/her statement for the past year. If not, please state "No account found" at the bottom of this page and mail back. All documents are to be confidential. Thank you.

Participant Signature

Date

Social Services Representative

Date

Witness (only if signature is by mark)

Date

ABSENTEE SHAWNEE TRIBE OF OKLAHOMA SOCIAL SERVICES
CONSENT TO RELEASE OF INFORMATION

TO: _____ RE: _____

_____ SS#: _____
_____ DOB: _____

You are hereby requested and authorized to release medical information from your records to:

Absentee Shawnee Tribe of Oklahoma
Social Services Department
2025 S. Gordon Cooper Dr.
Shawnee, OK 74801

INFORMATION REQUESTED:

Diagnosis and treatment: _____

Length of disability: Permanent – Years _____
 Temporary – Months _____
 Other _____

Expected release date for employment: _____

Participant Signature Date

Social Services Representative Date

Witness (only if signature is by mark) Date

ABSENTEE SHAWNEE TRIBE OF OKLAHOMA WORK SEARCH

RE: _____

SS#: _____

DATE: _____

To Whom It May Concern:

This is to advise you that the above named person has applied for financial assistance through this agency. In order to determine whether or not eligibility standards are met, we would appreciate it if you would give the following information.

Social Services Representative

TO BE FILLED OUT BY PROSPECTIVE EMPLOYER

This is to certify that the above named person has applied for employment at _____
_____ located _____
_____ and our number is (405) _____.

At this time there, **is work** or **is not work** available. Work is **Temporary**
 Permanent **Full-time** **Part-time**. This position will pay \$ _____ per hour.

Representative Name (please print)

Date

Representative Signature & Title