AVCP
Pouch 219*Bethel, AK 99559*
1-800-478-3157 or (907) 543-7300

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

For office use only
Date Received:____________
F. A. Date Rec'd:___________
____
Fee Agent's Signature

APPLICATION FOR SERVICES

WHAT KIND OF HELP DO YOU NEED? *PLEASE CHECK*

The Association of Village Council Presidents delivers services through the following program: Temporary Assistance for Needy Families. The Division of Public Assistance delivers services through the following programs: Adult Public Assistance; Food Stamps; General Relief Assistance; Chronic and Acute Medical Assistance; and Medicaid. For heating assistance use a separate form.

☐ Temporary Assistance	☐ Medicaid	☐ finding work
☐ Food Stamps	☐ Chronic and Acute Medical Assistance	☐ child care
General Relief Assistance	Adult Public Assistance	☐ child support
☐ rent or utilities	☐ assistance for the blind or disabled	☐ prenatal care
☐ burial expenses	☐ assistance for the elderly	☐ other_______________________

PLEASE PRINT

First Name and Middle Initial		Last Name		Social Security Number
Home Address / Directions to Your Home		City	State	Zip
Mailing Address		City	State	Zip
Home Phone Number	Message Phone Number	E-Mail Address	Other Names You Have Used:	

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NOTE: If more space is needed, please attach another piece of paper.

NAMES OF PEOPLE WHO LIVE WITH YOU *PLEASE PRINT*

Name	Relationship To you. If not related, write "NR"	Birth Date	Social Security Number	Citizenship Status – Check one: U.S. Citizen Or National	Citizenship Status – Check one: Alien in Satisfactory Immigration Status	Citizenship Status – Check one: Other	Sex Male (M) Female (F) Unborn (U)	Race (optional)	Highest Grade Completed
	Self								

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PLEASE PRINT

1. Is anyone in your household working and/or self-employed? ☐ ***Yes*** ☐ ***No*** *If yes, complete the information below.*

person employed	employer	# hours worked	monthly gross income
		/month	
		/month	
		/month	
		/month	

2. List any other money or income anyone in your household receives (not including income listed above).

owner/source/amount	owner/source/amount	owner/source/amount

3. List how much money your household has in cash or bank/credit union accounts.

amount in cash	amount in bank/credit union	account holder	bank/credit union name	account number
$	$			
$	$			
$	$			
$	$			

4. List any houses, cabins, property, stock, bonds, or other assets owned by anyone in your household.

owner	type of property/asset	value	owner	type of property/asset	value	owner	type of property/asset	value
		$			$			$
		$			$			$

5. List all vehicles owned by anyone in your household (include cars, truck, motorcycles, boats, RVs, snowmobiles, etc.)

owner/type of vehicle	model	year	value	amount owed
			$	$
			$	$
			$	$
			$	$

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6. List how much your family pays each month for rent/mortgage and utilities. *Do you pay for your home heating costs?* ☐ **Yes** ☐ **No**	**Rent/mortgage amount** $	utilities amount $
7. Does anyone in your household have child/dependant care expenses? ☐ **Yes** ☐ **No**		$ amount

8. Are you requesting assistance for anyone in your household who is pregnant? ☐ **Yes** ☐ **No** *If yes, who?* *When is the baby due?*
9. Has anyone in your household received public assistance in Alaska or any other state? ☐ **Yes** ☐ **No** *If yes, who, when, and where?*
10. Is any adult in your household fleeing from prosecution, custody, or confinement for a felony or a class A misdemeanor? *If yes, who?* ☐ **Yes** ☐ **No**
11. Have you or anyone in your household been convicted of a drug-related felony for an offense that occurred on or after August 22, 1996? *If yes, who?* ☐ **Yes** ☐ **No**

Answer questions 12-15 if you applying for medical assistance:

12. Is anyone in your household eligible for personal or employer-provided health insurance, Public Health Service, Indian Health Service, TRICARE (CHAMPUS), or VA benefits? ☐ **Yes** ☐ **No** *If yes, complete the following:*		
names of insured persons	insurance company name, address and phone number	policy and group number

13. Does anyone in your household have Medicare coverage? *If yes, complete the following:* ☐ **Yes** ☐ **No**			
person's name	medicare claim number	person 's name	medicare claim number

14. Does anyone in your household have unpaid medical bills from the last three months? ☐ **Yes** ☐ **No** *If yes, who?* *What months?*
15. Does anyone in your household have medical problems or medical costs due to an accident? ☐ **Yes** ☐ **No** *If yes, who?* *Date of the accident?*

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AUTHORIZED REPRESENTATIVE

I have asked this person to help with my temporary assistance case.

Name of Person ______________________ Phone/Message Number ______________________

ALTERNATE PAYEE

I want this person to be able to spend my public assistance benefits on behalf of my household. Which benefits? ☐ **Cash** ☐ **Food**

Name of Person ______________________ Phone/Message Number ______________________

Address ______________ City ______________ State ______________ Zip ______________

FOOD STAMPS SUBSISTENCE STATEMENT – FOR RURAL AREAS ONLY

My household intends to satisfy a substantial portion or our food needs by subsistence hunting and fishing. We do not intend to use these food stamps to buy equipment for commercial hunting and fishing. We understand we may not use these food stamps to buy guns, rifles, traps, fuel, ammunition, or clothing.

Signature of Applicant or Other Adult Household Member ______________________ Date ______________

STATEMENT OF TRUTH

Under penalty of perjury or unsworn falsification, I certify that the statements made on the application and during my interview for assistance regarding the persons in my home, the income, resources, property, and all other items that pertain to my possible eligibility fro benefits are true and correct to the best of my knowledge.

I have read or had read to me and understand my rights and responsibilities.

Signature of Applicant ______________ Date ______________ Signature of Other Adult Applicant ______________ Date ______________

Signature of First Witness if Signed with and “X” ______________ Date ______________ Signature of Second Witness of Signed with an “X” ______________ Date ______________

Signature of Case Manager or Helper ______________ Date ______________

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NOTES

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information requested by the Association of Village Council Presidents or by the Division of Public Assistance or its agent within the Department of Law. The requested information shall be used solely in the administration of the temporary assistance and public assistance programs, and will not be released to any other person or agency outside of the Association of Village Council Presidents or by the Division of Public Assistance or its agent within the Department of Law. This release of information shall be in effect while I'm an applicant or recipient of temporary assistance or public assistance, and for any later investigations pertaining to 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 Affairs, Alaska State Housing Authority, Social Security Administration, local governments, temporary assistance or public assistance program contractors and grantees, health care providers, tax assessors, financial institutions, Native Corporations, stock brokerage firms, landlords, employers, school authorities, and private individuals.

A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

Your Signature	Signature of Other Adult Household Member
Printed Name	Printed Name
Social Security Number	Social Security Number
Date	Date
Signature of First Witness if Signed with an "X"	Signature of Second Witness if Signed with an "X"
Printed Name of Witness	Printed Name of Witness

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REQUEST FOR CONTACT PERSONS AND ORGANIZATIONS

We often need to contact persons or organizations that can verify your situation to determine your eligibility for temporary or public assistance. When we contact such persons or organizations, we tell them our name, title, and that we work for the Association of Village Council Presidents or the Division of Public Assistance. We are prohibited by law from telling them anything about you or about your temporary or public assistance.

The information we most often need to verify is where you live, who lives with you, and your household's income and resources. We may also ask for information about absent parents for Temporary Assistance for Needy Families and Medicaid applicants.

Please provide the information requested below:

1. NAME OF SOMEONE WHO KNOWS YOU WELL: ____________________
   MAILING ADDRESS: ____________________
   DAYTIME PHONE NUMBER: ____________________

2. NAME OF SOMEONE WHO KNOWS YOU WELL: ____________________
   MAILING ADDRESS: ____________________
   DAYTIME PHONE NUMBER: ____________________

3. NAME OF LANDLORD: ____________________
   MAILING ADDRESS: ____________________
   DAYTIME PHONE NUMBER: ____________________

4. FINANCIAL INSTITUTION (BANK, CREDIT UNION, ETC.): ____________________
   ACCOUNT NUMBER(S): ____________________
   TELEPHONE NUMBER: ____________________

5. EMPLOYER: ____________________
   MAILING ADDRESS: ____________________
   TELEPHONE NUMBER: ____________________

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INFORMATION YOU NEED TO KNOW

NOTE: You are not required to provide a Social Security Number (SSN) or citizenship information fro anyone in your household who will not receive benefits from a public assistance program.

YOUR RIGHTS

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

Fair Hearings

If you disagree with an action taken by the TANF Program or the Division of Public Assistance that affects the benefits or services you receive, you can ask for a fair hearing. You may do this by phone, in person, or in writing by contacting anyone in the TANF Program or Public Assistance's Office. Usually, you must ask for a fair hearing within 30 days from the date of the agency notice. Food Stamp fair hearing requests must be made within 90 days from the effective date of the agency action. You may continue to receive Temporary Assistance, Adult Public Assistance, or Medicaid Program benefits until a hearing decision is made. Food Stamps can continue until a hearing decision is made or until the certification period ends if you request the hearing before the effective date of the action or within 10 days from the date the agency notice was mailed. At the hearing you may represent yourself or be represented by a legal representative, friend, or relative. You may qualify for free legal advice and representation by contacting the Alaska Legal Services Corporation.

Americans with Disabilities Act of 1990

The Alaska Department of Health and Social Services, Division of Public Assistance, and the TANF Program complies with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the Division's Americans with Disabilities Act Coordinator at (907) 465-3347 (voice and TDD).

Civil Rights

The U. S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, sex, religion, national origin, or political beliefs. Persons with disabilities who require alternative means for communication of program information should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whiten Building, 14th & Independence Ave. SW, Washington, D. C. 20250-9410 or call (202) 720-5964 (voice/TDD). No person in the United States, on the grounds of race, color, age, sex, disability, religious creed, political beliefs, or national origin shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program receiving federal assistance. If you believe you have been discriminated against, a complaint may be filed with:

Division of Public Assistance
PO Box 110640
Juneau, AK 99811-0640
(907) 465-3347

Dept. of Health & Social Services
Civil Rights Coordinator
PO Box 110651
Juneau, AK 99811-0651

Human Rights Commission
800 A Street
Anchorage, AK 99501
1-800-478-4692
TDD 1-800-478-3177

US Health & Human Services
Office of Civil Rights
2201 6th M/S RX-11
Seattle, WA 98121

YOUR RESPONSIBILITIES

You are primarily responsible for providing proof of you household situation.

Work Requirements

To receive Temporary Assistance and/or Food Stamps benefits, you may have to participate in work activities. 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 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.

Changes in Your 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 TANF Program or the Public Assistance office by phone, in person or in writing. You are required to report the following changes:

- 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
- Changes in the source of unearned income and changes in the amount of total unearned income greater than $25 a month
- When someone moves into or out of your home *(report within 5 days when a child leaves your home, if you get Temporary Assistance)*
- 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
- If your household gets a new vehicle
- If your household has more than $2000 total in cash or money in bank accounts
- Changes in your legal obligation to pay child support
- Changes in medical insurance, if your household gets medical assistance

Note: *If you receive Adult Public Assistance or APA Medicaid you must report all changes in employment and income*

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ASSIGNEMNT of RIGHTS

Child Support Information and Cooperation

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

When you apply for Temporary Assistance you must:

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

Any child support payments given or paid to you while receiving Temporary Assistance benefits must be reported and turned over to the State immediately. If you wish to negotiate or change a child support order, you must obtain a new court order, or get permission from CSED.

Medical Assignment of Rights

To receive Medicaid or Chronic and Acute Medical Assistance for you and your minor children you must:

- Assign to the State your right to any medical support or other payment for medical care;
- Agree to cooperate with the State in establishing paternity; and
- Cooperate with the State in obtaining any available third party payments such as an insurance payment or court settlement.

NOTE: If you believe you have a good reason not to cooperate with CSED for either Temporary Assistance or Medicaid program, you must tell your case worker immediately. You may be asked to provide information to support your reason.

Medical Records Release

When you sign the application for assistance and use Medicaid or Chronic and Acute Medical Assistance coupons, you consent to release medical records and information about you and other people upon whose behalf you are applying to the Division or its designee. Upon request, any person who has medical records and information or the custody of such records shall release those records to the Division or its designee.

Medical Reimbursement Agreement

If the State makes payment for services caused by injury or illness, you must agree to include all payments made by the State in any legal claim made against a third party and to notify the Division of Medical Assistance of that claim. If you receive an insurance or court settlement you must repay the State for the medical benefits provided as a result of the incident for which you are receiving the settlement. If married, but signing alone, you are acknowledging that benefits are for you, your spouse, or covered dependents. You and your spouse are both bound this agreement.

HOME VISITS

A TANF Program or Division of Public Assistance worker may visit your home and may contact other people to verify your eligibility for assistance.

FRAUD PENALTY WARNINGS

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 else get benefits. You must repay any money or benefit you wrongly receive.

If you misrepresent your residence or identify to receive multiple benefits you can be barred from receiving Alaska Temporary Assistance and food stamps for 10 years.

Under Temporary Assistance program rules, if you are convicted of fraud in court or an administrative hearing, you may not be able to get benefits for 6 months for the first time, 12 months for the second time, and permanently for the third time. Other penalties may also apply.

There are penalties for kickbacks, bribes, or rebates in furnishing Medicaid benefits. Penalties include fines up to $25,000 and/or imprisonment for up to five years. Conviction of an offense could cause loss of Medicaid benefits not to exceed one year.

Under food stamp rules if you are convicted of fraud or otherwise found to have intentionally broken the rules, you will be disqualified from the Food Stamp Program for one year for the first offense, two years for a second and permanently for a third. You may also be fined up to $25,000, imprisoned up to 20 years, or both. You may not use food stamps to buy items such as alcohol or tobacco. You may not sell or trade food stamp benefits, or use someone else's food stamp benefits. If you are convicted of using food stamp benefits to get drugs, you will be disqualified from the program for two years and permanently for a second offense. If convicted of trading or selling food stamps worth more than $500, or trading food stamp benefits for firearms, ammunition, or explosives, you will be permanently disqualified from the Food Stamp Program. Individuals convicted of drug-related felonies are barred from the Food Stamp Program.