Association of Village Council Presidents
AVCP BENEFITS DIVISION
Pouch 219 *Bethel, Alaska 99559
1-800-478-3157 or (907) 543-8650

APPLICATION FOR SERVICES

If you need help filling out this form or have questions, Please reach out to your local village based Navigator – They are there to help.

How do I apply?

- **You may see your local Navigator located in your village, go online at https://www.avcp.org and print out the application. You can also call 543-8650 and request to have a application mailed to your home.**

How long will it take?

- **The Benefit Technician and DPA employee has 30 days to work on your application from the date it arrives in our office. If your application has not been worked on or have not received a phone call or a notice, please call the office at (907) 543-8650.**
- *** Please do not forget to sign your application on the very first page***

Do I have to participate in an interview?

- **For Cash Assistance: Yes. A personal interview is required before we can determine if you are eligible for all cash assistance. You may schedule an interview at your village location with your local Navigator. A representative from the State of Alaska will also call you to set up an interview for all State of Alaska programs if applicable. Your application will be denied if you do not attend an interview within 30 days.**

What if something changes in my household once my application has been submitted prior to approval?

- **You must report changes in your household within 10 days of when you know of the change. If you receive Cash Assistance and a child leaves your home, you must report his within 5 days.**

The State of Alaska will process the SNAP component of the application in accordance with SNAP procedures, including timeliness, notice and FH requirements regardless of whether the application is for SNAP and other programs. Also, a Head of Household may not be denied SNAP benefits solely because they have been denied benefits from other programs. Also, if a SNAP claim arises against your household, the information on this application, including all Social Security numbers, may be referred to the Federal and State agencies, as well as private claims for collection agencies for claims collection actions.

What happens if I do not follow the State 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. *** Please keep this for your records***

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 20years 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

Alaska Temporary Assistance 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 •use my ATAP cash benefits or access them at any ATMs located in bars, liquor stores, gambling or adult entertainment establishments	•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

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

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To help expedite your Benefits Cash Assistance Application, please include all the required information to determine your family's eligibility with your completed application. The required information includes but is not limited to:

1. Clear copies of all ID cards for all adults living in the home.
2. Social Security numbers for all adults to be included in the case
    a. If you do not have a Social Security number, you must apply and be granted one to include the child or person.
3. Copies of all of the children's birth certificates.
4. Copies of all bank statements
5. Verification of family income: (paystubs, work statement, self employment ledger)
6. Completed work statement for all current jobs or for jobs that have ended within the past 60 days from date of application.
7. Copies of 2022 Social Security Award letters for everyone who is receiving benefits.
8. Copies of 2021 Commercial Fishing tickets, processor statements, and/or your 2021 taxes with the 1040 schedule C and verification of all commercial fishing expenses, for anyone who has a Commercial Fishing Permit. If the Permit holder did not commercial fish in 2021, we need a detailed statement (from the Permit holder) explaining why they did not use their Permit and if they will be using their permit during the 2022 Commercial Fishing season.
9. Completed Child Support Forms for all absent parent(s) currently not living in the home.
10. If you are applying for a relative child in State custody, a placement letter from the Office of Children's Services (OCS) or ICWA.
11. Copies of your bills (not receipts) for your utilities and a copy of your most recent stove oil receipt or Energy Assistance approval letter
12. Verification of your monthly mortgage statement or monthly rental charges.
13. Copy of pregnancy verification for anyone who is applying for TANF.

Your State of Alaska or Benefits Division application is not considered complete until we receive all necessary verification to determine your eligibility. Applicants can submit incomplete applications with names and dates of birth, and provide additional information at a later date. However, please be aware we cannot process incomplete applications. We have 30 days from the date we receive your application to determine if you are eligibility to receive any type of benefits. Your benefit start date begins the day you submit the application, as long as remaining verification documentation arrives within 30 days.

If you have any questions or need assistance completing your application, please contact your village Navigator or call AVCP Benefits Division at 543-8640 or 1-800-478-3157 ext 8650

AVCP BENEFITS DIVISION

Pouch 219*Bethel, AK 99559*
1-800-478-3157 or (907) 543-8650
APPLICATION FOR SERVICES

For office use only
Date Received:_____
C.W. Date Rec'd:_____
Case Worker Signature
_____

Please note: This application can be used by AVCP & DPA for TANF/DPA services.
BENEFITS WILL BE PROVIDED FROM THE DATE APPLICATION IS SUBMITTED.

WHAT KIND OF HELP DO YOU NEED? *PLEASE CHECK ALL THAT APPLY*
If you have questions, please contact: 907-543-8650 or 1-800-478-3321- ext 8650.

STATE of ALASKA SERVICES

☐ Food Stamps: Supplemental Nutrition Assistance Program (SNAP)
☐ Adult Public Assistance:
☐ Health Insurance: includes Medicaid, Denali Care, Denali Kids Care, tax credit, private health insurance
☐ Child Support

Please answer these questions to see if you get food stamps within 7 days.

1. Is cash and money in the bank $100 or less ☐ **Yes** ☐ **No**
2. Is the households monthly gross income less than $150 ☐ **Yes** ☐ **No**
3. Are your household's monthly rent/mortgage and utility payments more than your combined monthly gross income and liquid assets? ☐ **Yes** ☐ **No**

AVCP ONLY PROGRAMS:

☐ Cash Assistance: *TANF/BIA General Assistance*
☐ Energy Assistance: Heating fuel, electricity, gas, motor oil, wood *December 1st thru July 31st every year*
☐ Crisis Heating Assistance
☐ Weatherization
☐ Burial Assistance: ***Fill out pages 21-22 ONLY!***
☐ Emergency Assistance (Fire/Flood) (Fill out pages 1 &18)

What Tribe are you enrolled in? _____

SECTION 1. CASH ASSISTANCE

PLEASE PRINT

First Name and Middle Initial		Last Name		Social Security Number
Home Address / Directions to Your Home		City	State Alaska	Zip
Mailing Address		City	State Alaska	Zip
Home/Cell Phone Number (907)	Message Phone Number (907)	E-Mail Address	Other Names You Have Used:	

Rev 12/2021

SIGN HERE:_____ DATE: _____

Race: (*Optional- check all that apply*). ☐ Alaskan Native ☐ American Indian ☐ Caucasian ☐ Black or African American ☐ Asian ☐ Pacific Islander/Hawaiian ☐ Hispanic/Latino ☐ Canadian ☐ Other

If Hispanic/Latino (Please check all that apply): □ Mexican □Mexican/American □Chicano/a □Puerto Rican □ Cuban □ Other

The State of Alaska opts to use the Systematic Alien Verification and Eligibility (SAVE) System for status verification. All applicants may be subject to verification thru the submission of this information and it may affect Households eligibility and level of benefits.

INFORMATION ABOUT YOU AND ***ALL*** THE PEOPLE WHO LIVE WITH YOU: Please print***

This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

Name: *First, Middle initial and Last Name* of all household members. (even if not included in cash assistance)	Relationship to you. If not related, write "NR"	Birth Date	Mark if elder 60+ and/or legally disabled	Social Security Number	Sex Male (M) Female (F) Unborn (U)	Citizenship Status – Check one: U.S. Citizen Or National Have they lived in the US since 8/22/1996?	Citizenship Status – Check one: Alien in Satisfactory Immigration Status* Please provide document # and Date entered US	Is this person a spouse/ in activity duty or a veteran of the US Military?	**Who is to be included in the cash assistance case? Please check box**	Is anyone attending school Full time? Y/N	Level of Highest Grade Completed

Rev 11/2021

*Please put an ** by any person who is an active TANF/Cash Assistance **

PLEASE DECLARE Head of Household: _____

Is anyone a foster child in the home or a foster parent? If so who? _____

Please name children under 19 years of age you are the primary caretake for. This is for Medicaid purposes: _____

Is anyone incarcerated currently on the application? If so who? _____

The State of Alaska chooses to use the Income and Eligibility Verification System (EVS) to determine level of benefits. If there are discrepancies, it can affect households eligibility and level of benefits.

1. Is anyone in your household working Full/Part time/On-call and/or self-employed? ☐ ***Yes*** ☐ ***No*** *If yes, complete the information below.*
If Self Employed or a seasonal worker, please fill out forms A and/or B pages 6-7.

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). This includes Child Support

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(s): Type of property/asset Value	Owner(s): Type of property/asset Value	Owner(s) Type of property/asset value
$	$	$
$	$	$

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

Owner(s): type of vehicle	Model	Year	Value	Amount owed
			$	$
			$	$
			$	$
			$	$

Failure to report or verify any of the listed expenses below will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense. These expenses are also used in determining a Standard Utility Allowance that may increase your monthly cash assistance benefit.

6. List how much your family pays each month for rent/mortgage and other utilities. Rent/mortgage amount $_____ Who is required to pay the Phone Bill/How much? $_____ Light Bill? How much $ _____ Water and Sewer Bill?/$_____ Heating Fuel?/$_____ Anyone outside the household (boarder) help pay expenses? If so who:_____ How much and what amounts for each utility? _____	Monthly Utility cost amount $
7. Does anyone in your household have child/dependent care expenses? ☐ Yes ☐ No Please list child/dependent name and cost for that child/dependent. PERSON 1: _____$_____ PERSON 2:_____$_____ PERSON 3._____ $_____ PERSON 4: _____ $_____PERSON 5:_____ $_____	$ total amount Who pays for childcare/dependent expenses? Name: _____

8. Did you receive LIHEAP last year ☐ Yes ☐ No **8 a. Do you plan on applying for LIHEAP this year? ☐ Yes ☐ No**

9. Are you requesting assistance for anyone in your household who is pregnant? ☐ Yes ☐ No

If yes, who? *How many baby(s)?* *When is the baby due?*

10. Has anyone in your household received public assistance (Temporary Assistance, cash, food stamps, Medicaid in Alaska or any other state? ☐ Yes ☐ No *If yes, who, when, and where?*

11. Is any adult in your household fleeing from prosecution, custody, or confinement for a felony or a class A Misdemeanor? ☐ Yes ☐ No *If yes, who?*

12. 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? ☐ Yes ☐ No *If yes, who?*_____

12 a. Are they satisfactorily serving or successfully completed a period of probation or parole? ☐ **Yes** ☐ **No**

12 b. Are they in the process of serving or successfully completed mandatory participation in a drug or alcohol treatment program? ☐ **Yes** ☐ **No**

12 c. Have they taken action towards rehabilitation, including participation in a drug or alcohol treatment program? ☐ **Yes** ☐ **No**

12 d. Are they successfully complying with requirements of their re-entry plan? ☐ **Yes** ☐ **No**

13. Have you or any member of your household been convicted of buying, selling or trading SNAP benefits over $500 after September 22, 1996? ☐ Yes ☐ No

14. Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996 ☐ Yes ☐ No

15. Have you or any member of your household been convicted of trading SNAP benefits for: drugs, guns, ammunitions, or explosives after September 22, 1996? ☐ Yes ☐ No

16. Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail, for a felony crime or attempted felony crime, or violating a condition of parole or probation? ☐ Yes ☐ No

17. Does anyone in the household pay child support? ☐ Yes ☐ No * If YES, how much is obligated? _____ How much is actually paid? _____

Answer questions 18-32 only if you are applying for medical assistance:

18. 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

19. 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

20. Does anyone in your household have unpaid medical bills from the last three months? ☐ **Yes** ☐ **No** *If yes, who and what months?* _____ ***Do you want/need help paying for medical bills for the last three months?*** ☐ **Yes** ☐ **No**

If you need assistance paying for past medical bills, you will be required to provide proof of income and additional resources for all months requesting retroactive Medicaid assistance

21. Do you have any physical, mental, or emotional health conditions that cause limitations: (Like bathing, dressing, chores) or live in a medical facility or nursing home? ☐ **Yes** ☐ **No**

22. Does anyone in your household have medical problems or medical costs due to an accident? ☐ **Yes** ☐ **No**

If yes, who? *Date of the accident?*

23. Were you in foster care at the age of 18 years or older? **** This is a Medicaid required question**** ☐ **Yes** ☐ **No**

24. Do you plan to file taxes? ☐ **Yes** ☐ **No**

25. Did you file jointly with a spouse or anyone else? ☐ **Yes** ☐ **No: Name of spouse or person filing jointly with:** _____

26. Will you claim dependents on this tax return? ☐ **Yes** ☐ **No Please list dependents:**_____

27. Does anyone else claim any household members or children on their tax filings? ☐ **Yes** ☐ **No Please list household members who are being claimed by additional individuals:** _____

28. Will you be *claimed as a dependent* on anyone's tax return? ☐ **Yes** ☐ **No If so whose claiming, you and the relationship to the tax filer?** _____

DEDUCTIONS:

29. Is anyone claiming alimony? ☐ **Yes** ☐ **No If so who:** _____ **(This is a tax information needed for Medicaid Eligibility)**

30. Does anyone have student loan interest? ☐ **Yes** ☐ **No If so how much:$** _____

31. Any medical deductions? ☐ **Yes** ☐ **No If so how much:$** _____

32. Any other allowable tax deductions? ☐ **Yes** ☐ **No If so what and how much?** _____

33. Does anyone else outside the household help pay any medical/dependent care or shelter expenses? If so how much and who helps pay?_____

If you or anyone in the household is self-employed please fill out the form below

Form A – Self-Employment Income and Expenses

Examples of self-employment include: Commercial fishing, Babysitting or Day Care, Crafts, Carving, Owning own business, Rental Income or Permit Holder

Please provide a copy of your most recent Tax Return IRS 1040 and Schedules C, K, or S and any other tax forms supporting self-employment or partnerships. We can either deduct 50% of your gross earnings toward the cost of doing business or you can provide an itemized listing of all business related income and expenses received during the prior 12 months. If we do not receive this listing, we will use the 50% deduction for self-employment business expenses.

- Allowable business expenses are those expenses that are necessary, non-personal costs of doing business.
- Non-allowable business expenses are depreciation, amortization, and the principal portion of payments on business debt, personal, or home expenses which the household would incur regardless of the business.

Your total 12-month self-employment income, less allowable business related expenses, and any other earned and unearned income, will be divided by 12 to arrive at a monthly average. Attach additional pages as necessary.

If you are self-employed through commercial fishing, please send copies of your entire fishing settlement for the past 12 months. If you have computerized records, you may provide a copy of your ledger documenting your business-related income and expenses for the previous 12-month period. Please sign and date the ledger.

Head of Household:	Name of Self-Employed Person:
Type of Business:	Business Name:

Business Address:

Circle the past 12 months of self-employment:

20___ JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

20___ JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

You may be asked to provide additional documentation such as: copies of ledger books, trip tickets, or letters from people who have paid you, commercial fishing tickets and receipts.

Itemized Business Income			**Itemized Business Expenses**		
Date	Source	Amount	Date	Source	Amount
	12-month Income Total			12-month Expenses Total	

Attach additional pages as necessary.

I certify under penalty of perjury, or of unsworn falsification in violation of AS 11.56.210, that this income and expenditure information is true and correct to the best of my knowledge.

Signature **(Required)**: Printed Name: Date:

Form B – Seasonal Work Statement

Examples of seasonal employment include: Commercial fishing, Crewmember, Construction, Fish Processing, Logging, Mining, Firefighting, School district occupations

Be sure to submit proof of income from all sources. Your total income for the previous 12 months will be divided by 12 to arrive at a monthly average.

For application under Head of Household:	Employee Name:	SSN:
Employee Signature **(Required)**:	Occupation:	

For Employer Use Only

This form is to be used to verify seasonal employment income for the past 12-month period. Please complete, sign, and mail or fax this form to AVCP Benefits Division: Box 219 *Bethel, Alaska 99559 or fax 907-543-7949 . Your assistance is appreciated.

Date employment began:	Date first paycheck was issued:
Date employment ended (if employee is no longer working for you):	
Date last paycheck was issued:	Gross amount issued:

Circle the past 12 months of seasonal employment:

20___ JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

20___ JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Provide information below for the past 12-month period.

Gross Pay / Issue Date	Gross Pay / Issue Date	Gross Pay / Issue Date

Business Name:

Employer Address:

Employer Signature **(Required)**: Date:

Payroll Contact Phone Number:

*****Note: The employer must sign this Statement, otherwise it is not valid and will not be accepted as proof of income*****

SECTION 2. ENERGY ASSISTANCE: IF NOT APPLYING FOR LIHEAP SKIP TO THE NEXT PAGE

ADDITIONAL INFORMATION FOR LIHEAP ELIGIBILITY BEFORE YOU BEGIN!

If you are applying for TANF Benefits you can also be considered for LIHEAP if you qualify/wish. However, please review the following information:

There is only one (1) AVCP Energy Assistance Program award allowed per household per program year. By signing below you are certifying that no other member of your household has received a LIHEAP Benefit.

1. If your household has already applied between October 1, 2021 and July 31, 2022, and was approved, do not apply again.
2. If your household applied between October 1, 2021 and July 31, 2022, but was denied due to being over the income guidelines, please reapply in a new month if your income decreases.

LIHEAP ONLY: HEAT SOURCE AND SPLIT OPTION

What heat source are you requesting assistance with? **SELECT ONLY ONE!**

☐ **Heating/Stove Oil** *DEFAULT if none are selected

☐ **Gas and Motor Oil** to harvest own wood* (amount equals 50% of stove oil benefit)

**If you select Gas and Motor Oil, your EAP Award will provide you fuel to harvest your own wood. You will not be able to get Heating/Stove Oil or Napaimute Wood. Motor oil is 2-stroke, 4-stroke, and gear case outboard and snowmobile oil only.*

☐ **Napaimute Enterprises, LLC Wood** per cord, half cord chopped, and/or cubic foot.

Deliverable to: Akiachak, Akiak, Atmautluak, Kasigluk, Kwethluk, Napaskiak, Napakiak, Nunapitchuk, Oscarville, Tuluksak, Lower Kalskag, Upper Kalskag

Heat and Electricity Split Option:

Applicants **WILL NOT** be able to make changes once payment is made to vendors. Plan ahead and choose carefully.

☐ 100% Heat
☐ Default* 75% Heat, 25% Electricity
**If multiple/no selection(s) are made the default will apply*
☐ 50% Heat, 50% Electricity
☐ 25% Heat, 75% Electricity
☐ 100% Electricity

The EAP Award funds are **strictly** for home heating and electricity payments.
Non-chargeable items include groceries, propane, tanks and engine parts;
NOT FOR SUBSISTENCE/RECREATION USE!

ACCOUNT NUMBERS REQUIRED. COPY OF MOST RECENT BILL/STATEMENT REQUIRED.

Name of Fuel Company	**Account Number**	Name on Account	Amount of Current Bill/Credit
Name of Electric Company	**Account Number**	Name on Account	Amount of Current Bill/Credit

If your account for fuel or electricity is in someone else's name, please explain:

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: _____

FOOD STAMPS SUBSISTENCE STATEMENT – FOR RURAL AREAS ONLY

My household intends to satisfy a substantial portion of 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

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE(s):

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 your AVCP Workforce Navigator and State of AK DPA office. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative #1 :		Apartment or suite number
(First name, Middle name, Last name)		
Address:		
City:	State:	ZIP code:
Name of authorized representative #2:		Apartment or suite number
(First name, Middle name, Last name)		
Address:		
City:	State:	ZIP code:

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.

_____ _____

Signature of Applicant Date

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 Code

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, citizenship and or alien status and all other items that pertain to my possible eligibility for benefits are true and correct to the best of my knowledge. I have read or (had read to me) my rights and responsibilities as described in "Your Rights and Responsibilities" document during the program interview.

I understand that I must be a current Alaska resident to qualify for Public Assistance benefits administered by AVCP, Inc or the Alaska Division of Public Assistance. I further understand that, if my residency status changes, I must report the change to AVCP, Inc and/or the Alaska Division of Public Assistance within 10 days. I further understand that if I leave the state for 30 or more days, I must notify AVCP, Inc and/or the Alaska Division of Public Assistance of my absence, regardless of whether I consider myself an Alaska resident/intent to return to Alaska, or not.

I understand that eligibility for Public Assistance is determined in part by how much income my household has as its disposal. To that end I understand that this application requires that I disclose all income received by myself and members of my household, including but not limited to income from the following sources. Employment (including Self-Employment), Alimony, Child Support, Unemployment, Net Rental/Royalty, Pension/Retirement Supplemental Security Income, Veteran's Benefits, and Social Security Benefits.

I understand that eligibility for Public Assistance is determined in part by how many assets my household has at its disposal. To that end, I understand that this application requires that I disclose all assets possessed by myself and members of my household, including but not limited to the following types of assets: Property (regardless of whether the Property is paid for, still being paid for, or is jointly owned with someone else), all Bank Accounts (including checking and savings accounts), Cash on Hand, Certificates of Deposit, College Savings Plans, Life Insurance Policies, Pension Plans, Retirement Funds, Stocks Bonds and Annuities, Native Corporation Shares, Trust Funds, IRA Accounts, Commercial Fishing Permits, and Burial Policy Agreements.

Signature of Applicant	Date	Signature of Other Adult Applicant	Date
Signature of First Witness if Signed with and "X"	Date	Signature of Second Witness or Signed with an "X"	Date
Signature of Case Manager or Helper	Date		

Release of Information:

Your signature gives the Federally Facilitated Marketplace, the 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 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 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 my 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 the Division of Public Assistance and I may not have to cooperate.

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).
If this is incorrect, who is incarcerated? _____

Sign this application: _____

Signature **Date (month/day/year)**

Sign this application: _____

Signature **Date (month/day/year)**

************FOR OFFICE USE ONLY************

Date Application Received:_____ Application Received By:_____

DECISION OF APPLICATION: ☐ Approved ☐ Denied Date:____/_____/___

Review Dates for GA: _____/___/_____ _____/___/_____ _____/___/_____)
1-Month Review 3-Month Review 6-month Review

COMMENTS/NOTES:_____

_____

_____

_____

_____

_____

Caseworker Signature:_____ Date:____/_____/_____

CLIENT NAME: _____

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to discuss any action taken on your application or case with your Village Case Worker, AVCP Benefits Division employee or a State of Alaska DPA Employee. You are required to read, initial and sign, date this form at each section if you have no questions.

Information about Reporting Changes

This letter is to remind you of the need to tell us about changes in your household's situation. Changes need to be reported within 10 days from the day you first know about them. You can report changes in writing, in person, or by calling us at the number listed above.

If your household receives Food Stamps, you only need to report if your case goes **over income**. If your household includes an ABAWD (able bodied adult without dependent), you must report if the ABAWD's monthly work activity goes below 80 hours.

If you household receives Tribal Temporary Assistance, SNAP, Family Medicaid or Child Support, 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
- Change in the source of unearned income greater than $50 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 or we cannot use them in calculating your benefits.
- If your household purchases a vehicle. (car, truck, snow-go, 4 wheeler or boat and motor)
- If your household has more than $2000 total in bank accounts
- Changes in your legal obligation to pay child support
- Changes in medical insurance if you household gets medical assistance

If you receive Adult Public Assistance or related Medicaid you must report all changes to your Public Assistance case worker, including any changes in medical insurance. Please call me if you have any questions about this letter.
_____Initials _____Initials

WORK REQUIREMENTS

To receive Cash Assistance benefits, you may have to participate in work activities. Cash 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. Federal Regulations require Cash Assistance clients to maintain 25 hours of work activities every week to be in compliance with TANF. If you are an unmarried minor parent, to receive Cash 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. _____Initials _____Initials

HOME VISITS

An AVCP Benefits Division 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. A home visit may also be conducted if you are under a Tribal Temporary Assistance penalty. For these several types of home visits, an appointment will be set up with the participant ahead of time. It is in your best interest to cooperate with a Penalty Home Visit. Failure to comply or cooperate with the Home Visit may or will result in case closure.

_____Initials _____Initials

FRAUD PENALTY WARNINGS:

This application is subject to verification by Federal, State or Local officials to determine if the information is factual. If any information is incorrect the State of Alaska Department of Public Assistance Program Benefits or Benefits Division Benefits may be denied and applicant may be subject to criminal prosecution for knowingly providing incorrect information to receive benefits you are: not eligible for, or to help someone else get benefits for which they are not eligible. You must repay any benefits you wrongly receive. Under Benefit Division 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 conviction, 12 months for the second conviction, and permanently for the third conviction. Other penalties may also apply. If a court of law finds you guilty of having using or received benefits in a transaction involving the sale of firearms, ammunition, or explosives, you will be permanently ineligible to participate in the SNAP program upon the first occasion of such a violation.

If you are found to have made a fraudulent statement or representation with respect to identity or place of residence in order to receive multiple benefits including SNAP, you can be ineligible to participate in the SNAP program for a period up to 10 years.

If a court of law finds you guilty of having trafficked benefits for a total amount of $500 or more, you can be permanently ineligible to participate in the SNAP program for the first occasion for such a violation.

_____Initials _____Initials

60 MONTH LIFETIME LIMIT

The Association of Village Council Presidents, Inc. has determined that it will implement the State of Alaska's time limits to minimize the differences between the Tribal TANF and the State's ATAP. Thus, families are not eligible for a Tribal TANF payment when the family includes an adult who has received benefits under (1) this Tribal TANF plan, or (2) a TANF-funded program in another State or operated by another tribe, for a total of 60 months. AVCP will count prior months of assistance funded with TANF block grant funds except for any month exempt or disregarded by statute or regulation.

Mandatory Exemption: In determining the number of months for which an adult has received assistance under a State or Tribal Program, the Tribal TANF will disregard any months during which the adult lived in Indian Country or an Alaska Native village according to the most reliable data available with respect to the month (or a period including the month) indicating that at least 50 percent of the adults living in Indian Country or in the village were not employed. "Indian Country" shall have the meaning given such term in section 1151 of Title 18, United States Code.

_____Initials _____Initials

SUPPORTIVE SERVICES

Supportive Services are approved on a case-by-case basis after examining the family's circumstances, determining if the family is in compliance with TANF regulations and concluding the family truly has a need for a service that will assist the family in achieving self-sufficiency. Families are not guaranteed Supportive Services simply because they request help or request for Supportive Services. If Supportive Services are approved, it can be revoked at any time. All Supportive Service payments will be paid directly to the vendor(s).

Remember participants must take part in work activities. Participants who fail to take part in work activities incur a penalty that reduces their TANF benefits and/or ineligible for Supportive Services.

_____Initials _____Initials

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 AVCP 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 good reason not to cooperate with CSSD for the Tribal Temporary Assistance program, you must tell your case worker 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 AVCP Tribal Temporary Assistance Program your right to receive and keep child support payments due to a child or children 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.

_____Initials _____Initials

AMERICANS WITH DISABILITIES ACT OF 1990

The Benefits Division Program and the State of Alaska Division of Public Assistance 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).

_____Initials _____Initials

SOCIAL SECURITY NUMBERS

A social security number must be provided for the applicant, the parents of the child whether included in the household or not, and each other person who will benefit from AVCP Benefits Division or Division of Public Assistance Programs, including caretaker relatives in the household and dependent children.

_____Initials _____Initials

FAIR HEARINGS

If you disagree with an action taken by the Benefits Program 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 Benefits Program. Usually, you must ask for a fair hearing within 30 days from the date of the agency notice. You may continue to receive Temporary Assistance until a hearing decision is made, but LIHEAP benefits may be placed on hold. 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. Results based on findings of the fair hearing may require ineligible beneficiaries to return any benefits that were in question.

_____Initials _____Initials

NON DISCRIMINATION

Title VI of the 1964 Civil Rights Act states "NO PERSON IN THE UNITED STATES SHALL, ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN, BE EXCLUDED FROM PARTICIPATION IN, BE DENIED THE BENEFITS OF, OR BE SUBJECTED TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY RECEIVING FEDERAL FINANCIAL ASSISTANCE."

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the base of race, color, nation origin, sex, age, religion, political beliefs, or disability. To file a compliant of discrimination please send a letter to AVCP Legal PO BOX 219 Bethel, AK 99559 and USDA Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S. W., Washington D.C. 20250-9410 or call (202)720-5964. USDA is an equal opportunity provider and employer.

I certify that I have read, or have had this document read to me and understand the entirety of this document.

_____ _____

Signature of Participant/Date **Signature of Other Adult/Date**

_____

Signature of Witness/Date

CHILD SUPPORT INFORMATION (TANF)

COMPLETE A **SEPARATE** FORM FOR **EACH** NONCUSTODIAL PARENT. PLEASE **PRINT** IN INK.

The information you provide will be used to establish and/or enforce child support based on an open TANF case.

Your name: _____ Your SSN: _____

Address: _____ City/State/Zip Code: _____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	State child conceived in	Date Of birth	Place of birth (city, county, state)	Child's SSN	Father's full name	Is father on birth certificate?
						O Yes O No
						O Yes O No
						O Yes O No
						O Yes O No
						O Yes O No
						O Yes O No
						O Yes O No

Non-custodial Parent's: 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? ☐ Yes ☐ No Type/Policy: _____

Union member? _____ Tribe or Native Corporation member? _____

☐ Married: Date: _____ Where: _____

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

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

☐ Divorced: Date final: _____ Where: _____

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/ ASSIGNMENT OF SUPPORT

You are required by law to help get child support for a child receiving Temporary Assistance (ATAP/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.

☐ *If CSSD sends a child support payment to you in error, they will contact you to arrange repayment of that money. If you want to repay the overpayment 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 _____

ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS
BENEFITS DIVISION
POUCH 219 · BETHEL, ALASKA 99559
Toll Free: (800) 478-3521 ext. 8650 · Direct (907) 543-8650
Fax (907) 543-7479

APPLICATION FOR BURIAL ASSISTANCE

Name of Deceased: _____

Deceased's Date of Birth: / / Date of Death: / /

Tribe Enrolled To: Tribal Enrollment #:

Deceased's Last Address:

P.O. Box or Street Address *City* *State* *Zip*

*****The deceased must have resided in the service area.*****

Name of Relative Applicant: Relationship to Deceased:

Mailing Address:

P.O. Box or Street Address *City* *State* *Zip*

Home/Cell Phone#: Message Phone#: Work Phone#:

What are the plans you have arranged for the burial?_____

_____

_____

_____

Name of Mortuary:_____

Address:_____

City:_____State:_____ Zip Code:_____

Contact Person:_____Phone:_____ Fax:_____

Will the casket be built? ☐ Yes ☐ No If yes, by whom? Please write information below.

Name:_____Address:_____

City:_____ State:_____ Zip:_____Phone:_____

Vendor Name:_____Building Material Cost: $_____

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Person:_____

ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS
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RECORD OF INCOME AND RESOURCES

Did the DECEASED have income from any source? ☐Yes ☐No

If yes, please list source of income and amounts below.

Applicant must provide proof of ALL income & resources for 30 days prior to signature date

SOURCE OF INCOME	*AMOUNT*	SOURCE OF INCOME	*AMOUNT*
Salary #1: Deceased's Income/Salary	$	Worker's Compensation	*$*
Salary #2: Spouse's Income/Salary	$	Medicare or Medicaid	*$*
*Adult Public Assistance	$	Veterans Benefit	*$*
*TANF/ATAP	$	Checking Account	*$*
*Public Assistance Burial Funds	$	Savings Account	*$*
*State Longevity (Senior Benefits)	$	DONATION -Community	*$*
Social Security (SSA) or SS Retirement	$	DONATION-Tribal org Organization	$
Supplemental Security Income (SSI)	$	DONATION-Native Corporation	$
Disability Insurance	$	Other	$
Pension or Retirement	$	Other	$
Unemployment Benefits	$		
TOTAL RESOURCE INCOME	$		

A deceased person who was receiving Adult Public Assistance, Senior Benefits or TANF/ATAP will have their burial assistance provided through the State of Alaska, per section 2103.7 of the State of Alaska – General Relief Assistance (GRA) Manual. These persons are automatically not eligible for BIA Funded Burial Assistance

READ BEFORE SIGNING

I apply for financial assistance for burial assistance services for the deceased who is in need. I, have received a copy of and have had explained to us, 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 my protection under the Paperwork Reduction Act and the Privacy Act.

_____
Relative Applicant Signature

_____
Printed Name

_____
Date