PETERSBURG INDIAN ASSOCIATION
SOCIAL SERVICES DEPARTMENT
APPLICATION FOR WELFARE, BURIAL, and EMERGENCY ASSISTANCE

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

Name:

Maiden Name or Other Names Used: **Date of Birth:** / /

Mailing Address:
P.O. Box or Street Address City State Zip

Physical Address:
Street Address City State Zip

Home Phone#: **Message Phone#:** **Work Phone#:**

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

List ALL MEMBERS of the Household. Enter an asterisk (*) in the box at left of the name for each person NOT INCLUDED in General Assistance application budget.

*	NAME	RELATION TO HEAD	DATE OF BIRTH	SEX	SOCIAL SECURITY #	TRIBE ENROLL #	MONTHLY INCOME
		self					

MEMBERS OF HOUSEHOLD WITH PHYSICAL OR MENTAL HANDICAP

NAME	NATURE OF PROBLEM	TEMPORARY or PERMANENT	MINOR or MAJOR	VERIFIED

How many persons live in the house: _______Adults _______Children

Type of Service Applying for: ☐ Burial Assist ☐ ☐General Assistance ☐Emergency *for home burnout, flooding, etc. NOT for eviction/shutoff notices, medical travel, funeral travel, etc. per 25 CFR Part 20 §20.329.

Where do you live now? ☐Own Home ☐Rent House/Apartment ☐Rent Room ☐With Relatives ☐With Friend(s) ☐Other:__________________

Are you or any member of your household a shareholder in a Native Corporation? ☐Yes ☐No
If yes, list the name of household member and Corporation(s) here: (use backside of form if necessary)

MEMBERS OF HOUSEHOLD WHO OWN SHARES IN A NATIVE CORPORATION

NAME	NATIVE CORPORATION	# SHARES OWNED

Have you received ATAP or TANF in the last month: ☐Yes ☐No If yes, how much: $__________

Has your ATAP/TANF been reduced due to penalties: ☐Yes ☐No Reason:__________

Have you been terminated from ATAP/TANF: ☐Yes ☐No Date of termination:___/___/___

Have you been determined ineligible for ATAP/TANF: ☐Yes ☐No Reason:__________

Have you been denied ATAP/TANF: ☐Yes ☐No Reason:__________

Are you eligible to reapply for ATAP/TANF: ☐Yes ☐No Date able to reapply:___/___/___

What TANF office did you receive assistance from: Please list:__________

EXPLAIN *FULLY*, how you have supported yourself during the past three (3) months ***and*** what has changed in your situation to cause you to apply for assistance. Failure to complete this section will render this application incomplete & therefore will not be processed.

____

____

____

____

____

RECORD OF INCOME AND RESOURCES

Does anyone in your household have income from any source? ☐Yes ☐No

If yes, list the name of household member(s), source of income and amounts below.

*******YOU ARE REQUIRED TO REPORT INCOME RECEIVED FROM THE FOLLOWING******

SOURCE OF INCOME & RESOURCES	AMOUNT	NAME OF HOUSEHOLD MEMBER
Salary #1: Applicant's Income/Salary	$	
Salary #2: Spouse's Income/Salary	$	
Tips or Gratuities	$	
ATAP –TANF-ASAP (State assistance)	$	
Child Support and Alimony	$	
Foster Care Payments	$	
Adult Public Assistance (APA)	$	
Social Security (SSA)	$	
Supplemental Security Income (SSI)	$	
Disability Insurance	$	
Alaska State Permanent Fund (PFD)	$	
Cashouts of Retirement or Pension Plans	$	
State Longevity	$	
Veteran's Benefit	$	
Unemployment Insurance Benefits	$	
Worker's Compensation	$	
Food Stamps	$	
Medicare/Medicaid	$	
Native Corporation Dividends	$	
Checking Account	$	
Savings Account	$	
Student Loans/Grants/Scholarships	$	
Bingo or Pull Tab Winnings	$	
Other Income	$	
TOTAL MONTHLY INCOME	$	

MONTHLY SHELTER COSTS

******PROVIDE ALL EXPENSES/RECEIPTS FOR THE CURRENT MONTH******

Rent	$	Telephone	$
Space Rent	$	Water	$
Mortgage Payment	$	Sewer	$
Electricity	$	Household Oil/Fuel/Wood	$
Heating	$	Other	$

READ BEFORE SIGNING

**I/We apply for financial assistance/ services for the listed members of my (our) household who are in need.
I/We have received a copy of and have had explained to us, and understand the provisions of Federal Law governing fraud.**

❑ **Applicants or recipients who knowingly and willfully provide false or fraudulent information are subject to prosecution under 18 U.S.C. §1001, the Federal Law concerning fraud which carries a fine of not more than $10,000 or imprisonment of not more than five years or both.** **Initials of applicant**__________

❑ **I (We) agree to supply information regarding resources and income and to notify the agency of any changes in my (our) situation. Release of Information: AVCP is authorized to obtain/exchange information necessary to establish eligibility for assistance. I (We) have read, or had explained to me/us, the provision of our protection under the Paperwork Reduction Act and the Privacy Act.** **Initials of applicant**__________

Applicant Signature	Signature of Other Adult Household Member
Printed Name	Printed Name
Date	Date

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

Date Application Received:________________Application Received By:________________________________

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

(Review Dates: ______/___/______ (1-Month Review) ______/___/______ (3-Month Review) ______/___/______ (6-month Review))

COMMENTS/NOTES:____

Caseworker Signature:________________________________Date:____/____/____

PETERSBURG INDIAN ASSOCIATION
P.O. BOX 1418
PETERSBURG, AK 99833
PHONE: 907-772-3636
FAX: 907-772-3637

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________ , hereby authorize the release of information requested by Petersburg Indian Association (PIA) General Assistance Program. The requested information shall be used solely in the administration of General Assistance and will not be released to any other person or agency outside the General Assistance Program or its agents. I hereby authorize PIA to obtain and exchange information related to my applications to participate in their programs. And, to arrange for such participations based on my employability assessment and plan to employment related activities. This release of information shall be in effect while I am an applicant or recipient of General Assistance, and for any later investigations pertaining to my eligibility and receipt of General Assistance 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 and tribal governments, public assistance program contractors and grantees, health care providers, tax assessors, financial institutions, Native corporations, stock brokerage firms, landlords, employers, school authorities, private individuals and all departments and programs within and administered by PIA.

FRAUD NOTICE: Under 18 U.S.C § 1001, the Federal Law concerning fraud states: "Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or devise a material fact, or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both."

A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL

____
Applicant Signature

____
Printed Name of Applicant

____
Date of Applicant Signature

____
Signature of Witness if signed with an "X"

____
Printed Name of Witness if signed with an "X"

____
Date of Witness Signature

Client Case File: this records all applications and other referrals for services to the Social Services program, the type of service(s) requested, and the disposition of the intake activity (accepted for further services, referred to other programs, problem resolved at intake, ineligible, etc.)

Client files must contain the following as required by 25 CFR Part 20, November 2000.

- ☐ Client application or written request or referral for services.
- ☐ Basic personal data for individual or family (on the application)
- ☐ Proof of eligibility for program services (tribal enrollment, CDIB, etc.).
  Tribal Enrollment #_________ Verified by____________
- ☐ Proof of residency. (Utility bill).
- ☐ Verification of income and resources. Or completed Zero Income Statement
- ☐ Client Individual Self-Sufficiency Plan (for GA clients).
- ☐ Client Case Plan.
- ☐ Documentation of other programs or agencies with whom services will be coordinated.
  (See above ***Client Case File***)
- ☐ Client Case Notes documenting contact with clients.
- ☐ Decision Letters approving, disapproving, or pending applications.
- ☐ Welfare Assistance Calculation Worksheet

Do you qualify for American Rescue Plan Welfare Assistance:

I am or a household member is currently enrolled with Petersburg Indian Association and have lived in Petersburg continuously since May 6, 2021. __________ ***(initial)***

I or a tribal household member has incurred economic hardship caused by the COVID-19 public health emergency. ________________***(initial)***

I or a tribal household member continues to face economic hardship due to the COVID-19 public health emergency. _____________ ***(initial)***

____

Print Name Signature Date

ELIGIBILITY

INDIAN BLOOD *(25 CFR §20.100)*

Applicant must (1) be a member of a federally recognized Indian Tribe, or (2) in the Alaska service area only, any person who meets the definition of "Native" as defined under 43 U.S.C. 1602(b): "a citizen of the United States and one-fourth degree or more Alaska Indian." It includes, in the absence of proof a minimum blood quantum, any citizen of the United States who is regarded as an Alaska Native by the Native village or Native group of which he claims to be a member and whose father or mother is (or, if deceased, was) regarded as native by a village or group.

RESIDENCY *(25 CFR §20.100 & §20.300)*

To be eligible for assistance or services, an applicant must reside in a designated service area.

ELIGIBILITY FOR OTHER SERVICES

Applicants must not be receiving or eligible to receive County/State Public Welfare or Social Security Income. An individual or family who is presumed to be eligible for these programs may, after providing evidence of having applied for those benefits, be granted General Assistance (GA), pending approval of such application. Also, all clients applying for GA who are eligible for assistance from other programs such as Social Security, Unemployment Benefits, Worker's Compensation, Veteran Benefits, Retirement, etc., will be required to seek and show that they have applied for that assistance. The BIA Financial Assistance and Social Services programs are a secondary resource and cannot be used to supplant or supplement other programs.

POLICY ON EMPLOYMENT: ACCEPTANCE OF AVAILABLE EMPLOYMENT *(25 CFR §20.314)*

An applicant must actively seek employment including the use of available state, tribal, county, local or Bureau-funded employment services, which they are able and qualified to perform. This means that a recipient, prior to and after applying for GA, must continue to actively seek employment. An applicant or recipient of GA who is determined employable must also accept local and seasonable employment when it is available. According to 25 CFR §20.316, the recipient must demonstrate that they are actively seeking employment by providing the Human Services worker with evidence of job search activities as required in the Individual Service Plan (ISP) and if they do not seek available local and seasonal employment or quit a job without good cause, they cannot receive GA for a period of at least 60 days but not more than 90 after they refuse or quit a job.

Applicants must report all current and expected employment and income. Those claiming temporary or permanent disability are required to present documented medical verification of such disability.

REPORTING REQUIREMENTS

It is the responsibility of all Financial Assistance applicants to report and present appropriate documentary verification of any and all changes that may occur in their income or living arrangements. Failure to do so may constitute fraud and be subject to prosecution and/or repayment of disbursements. Each of the following must be reported as they occur:

- A move from one residence to another
- Addition to or reduction in household members
- Payments received from boarders or lodgers
- Changes or adjustments in housing or Utility Costs
- A move from the Reservation Area, Designated Service Area, or Alaska Native Village

PETERSBURG INDIAN ASSOCIATION
Po Box 1410
Petersburg, AK 99833
(907) 772-3636 Fax (9070 772-3637
ga@piatribal.org

WORK SEARCH/WORK RELATED ACTIVITY SHEET

NAME OF APPLICANT: ____________________ **SSN:** ***/**/____ **DOB:** ____/____/____

Applicant:
Please read carefully. Ask your Welfare Assistance Case Worker to clarify if you do not understand these requirements.

1. All employable adults in your household are required to apply for a minimum of twelve (12) different jobs for the month that you have applied for Welfare Assistance.

2. You must complete six (6) work searches within two weeks from the date of your application.

3. The remaining six (6) work searches must be completed before the end of the month in which you applied.

4. Actively looking for work is one of the goals in your Individual Self-Sufficiency Plan (ISP).

5. Take the Work Search form to various businesses and submit an application for employment. The potential employer must sign and date the Work Search form which verifies that you have applied for work. Return the Work Search forms to the Welfare Assistance Worker.

6. You may also show proof that you are actively participating in work related activities such as obtaining a GED; doing consistent volunteer work; working with Job Service to develop your resume (work history). Provide proof to your Welfare Assistance Case Worker of these activities within two weeks of the date of your application. The proof is a document from the place where you are doing these work-related activities.

Date of your Application:

First 6 worksheets due:

Last 6 worksheets due:

If you do not complete the work searches, you will not receive GA.

____

Employer: Please complete the information below for the applicant who is pursuing employment with your organization or business.

NAME OF APPLICANT: ____

WORK SEARCH/WORK RELATED ACTIVITY # 1			
Date:	Job Title/Work Activity:		
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	☐ Yes ☐ No	Was Applicant Offered Employment	☐ Yes ☐ No
Submitted a Resume	☐ Yes ☐ No	Did Applicant Accept Employment	☐ Yes ☐ No
Was Applicant Interviewed for Job	☐ Yes ☐ No	Did Applicant Refuse Employment	☐ Yes ☐ No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 2			
Date:	Job Title/Work Activity:		
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	☐ Yes ☐ No	Was Applicant Offered Employment	☐ Yes ☐ No
Submitted a Resume	☐ Yes ☐ No	Did Applicant Accept Employment	☐ Yes ☐ No
Was Applicant Interviewed for Job	☐ Yes ☐ No	Did Applicant Refuse Employment	☐ Yes ☐ No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 3			
Date:	Job Title/Work Activity:		
Employer or Business Phone #:		Employer or Business Name:	
Employer or Business Address:			
Submitted a Complete Application	☐ Yes ☐ No	Was Applicant Offered Employment	☐ Yes ☐ No
Submitted a Resume	☐ Yes ☐ No	Did Applicant Accept Employment	☐ Yes ☐ No
Was Applicant Interviewed for Job	☐ Yes ☐ No	Did Applicant Refuse Employment	☐ Yes ☐ No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

____

Employer: Please complete the information below for the applicant who is pursuing employment with your organization or business.

NAME OF APPLICANT: ______________________________________

WORK SEARCH/WORK RELATED ACTIVITY # 1			
Date:	Job Title/Work Activity:		
Employer or Business Phone #:	Employer or Business Name:		
Employer or Business Address:			
Submitted a Complete Application	☐ Yes ☐ No	Was Applicant Offered Employment	☐ Yes ☐ No
Submitted a Resume	☐ Yes ☐ No	Did Applicant Accept Employment	☐ Yes ☐ No
Was Applicant Interviewed for Job	☐ Yes ☐ No	Did Applicant Refuse Employment	☐ Yes ☐ No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 2			
Date:	Job Title/Work Activity:		
Employer or Business Phone #:	Employer or Business Name:		
Employer or Business Address:			
Submitted a Complete Application	☐ Yes ☐ No	Was Applicant Offered Employment	☐ Yes ☐ No
Submitted a Resume	☐ Yes ☐ No	Did Applicant Accept Employment	☐ Yes ☐ No
Was Applicant Interviewed for Job	☐ Yes ☐ No	Did Applicant Refuse Employment	☐ Yes ☐ No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

WORK SEARCH/WORK RELATED ACTIVITY # 3			
Date:	Job Title/Work Activity:		
Employer or Business Phone #:	Employer or Business Name:		
Employer or Business Address:			
Submitted a Complete Application	☐ Yes ☐ No	Was Applicant Offered Employment	☐ Yes ☐ No
Submitted a Resume	☐ Yes ☐ No	Did Applicant Accept Employment	☐ Yes ☐ No
Was Applicant Interviewed for Job	☐ Yes ☐ No	Did Applicant Refuse Employment	☐ Yes ☐ No
Employer/Supervisor Signature:		Printed Name:	
COMMENTS:			

Redetermination Date (3 months: ISP)/ (6 months: Case Plan) (mm/dd/yyyy)/ Initials: _____/_____/_____ / _________

Date GA Recipient met ALL goals (mm/dd/yyyy) (mm/dd/yyyy)/ Initials: _____/_____/_____ / _______

INDIVIDUAL SELF-SUFFICIENCY (ISP)/ CASE PLAN (25 CFR Part 20)

☐ ISP / ☐ Case Plan [Check all that Apply]

Name of Client: (Last, First, Middle): ______________________________ **Date of Plan:** _____/_____/_____

What is/are your goals to achieve self-sufficiency?

Short-Term Goals:

Long-Term Goals:

BARRIERS TO CLIENT

- ☐ Health
- ☐ Mental Health
- ☐ Substance Abuse Dependency
- ☐ Age Factors
- ☐ Disabilities
- ☐ Lack of/ Limited Transportation
- ☐ Lack of/ Limited Education
- ☐ Criminal History
- ☐ Limited/ No Work History
- ☐ No Job Skills
- ☐ No Driver's License
- ☐ Social Isolation
- ☐ Limited/No Jobs Available
- ☐ Homeless
- ☐ Other: _______________

STRENGTHS OF CLIENT

Identify strengths the client possesses:

STEPS NEEDED TO ACHIEVE SELF-SUFFICIENCY

WORK ACTIVITIES

- ☐ Job Search
- ☐ Volunteer Work Experience
- ☐ Job Sampling or Job Shadow
- ☐ On-the-Job Training
- ☐ Employment Counseling
- ☐ Registration with Local Job Service
- ☐ Job Readiness
- ☐ Other: _______________

EDUCATION/ TRAINING

- ☐ High School Diploma
- ☐ GED
- ☐ ESL (English as 2nd Language)
- ☐ Adult Vocational Training
- ☐ Literacy Improvement
- ☐ Higher Education
- ☐ Other: _______________

OTHER ACTIVITIES

- ☐ Life Skills Activities
- ☐ Parenting Skills
- ☐ Childcare Assistance
- ☐ Child Support
- ☐ Substance Abuse Treatment
- ☐ Counseling
- ☐ Driver's License Reinstatement
- ☐ Dental/Health Care
- ☐ Other: _______________

CASE PLAN

- ☐ SSA Application
- ☐ Medical Report
- ☐ Decision Letters
- ☐ Legal Assistance
- ☐ Care for Child Under Age 6
- ☐ Other: _______________

SELF SUFFICIENCY ACTION PLAN & GOALS

GOAL #1		
Goal #1 Revised		
ACTION STEPS FOR GOAL #1	**DATE TO BE ACHIEVED**	**DATE COMPLETED**
1.		
2.		
GOAL #2		
Goal #2 Revised		
ACTION STEPS FOR GOAL #2	**DATE TO BE ACHIEVED**	**DATE COMPLETED**
1.		
2.		
SOCIAL SERVICES WORKER'S ACTIVITY WITH TIMEFRAME (25 CFR 20.318)	**DATE TO BE ACHIEVED**	**DATE COMPLETED**
1.		
2.		

____ By initialing you understand that the purpose of the Individual Self-Sufficiency Plan (ISP) is to meet the goal of employment through specific action steps and I am required to follow the steps developed in the ISP. I understand that I must participate in work activities and/or other activities and referrals developed in this plan that will promote my self-sufficiency. Failure to follow through with the ISP may constitute suspension from the General Assistance Program for a period of at least 60 days but not more than 90 days. I also understand that if there are any changes to be made that I will contact my Case Worker in a timely manner to ensure my success in the General Assistance Program.

____ By initialing you understand that the purpose of the Case Plan is to follow through with goals listed: (i.e.) Accessing other resource programs, keeping medical appt., etc. Failure to follow through with the steps identified in the Case Plan may constitute suspension from the General Assistance Program.

_______ ______________________________ _______ ______________________________

Date Signature of Applicant Date Signature of Social Service Worker

_______ ______________________________

Date Signature of Bureau Line Office (if applicable)

Privacy Act Statement

25 CFR Part 20 and 25 U.S.C. 13 authorize the collection of this information. The information is confidential and is never disclosed without written clearance and consent of the applicant. The primary use of this information is to determine eligibility for financial assistance and services from the Bureau of Indian Affairs (BIA) Child Welfare, Burial, and Disaster programs. Additional disclosures of the information may be to other BIA or tribal officials in the conduct of their official duties pertaining to the application for financial assistance or services, or in the conduct of program review and to the Office of the Inspector General or the General Accounting Office when conducting an audit of BIA programs, or local law enforcement agency when the Agency becomes aware of violation or possible violation of civil or criminal law, and to the General Services Administration in connection with its responsibility for records management. This information will be entered into the BIA, Social Services system of records which can be obtained upon request from Chief, Division of Social Services, 1849 C Street, NW, MS-3647-MIB, Washington, DC 20240. No record contained therein may be disclosed by any means of communication to any person, or to another agency, except pursuant to a written request by, or with prior written consent of the individual to whom the record pertains. Executive Order 9397 authorizes the collection of your Social Security number. Furnishing the information is voluntary but failure to do so may result in disapproval of your application. If the BIA uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

Paperwork Reduction Act Statement

The information is being collected to determine applicant eligibility for financial assistance and services and to provide Bureau of Indian Affairs (BIA) managers with information for program planning, reporting and utilization. Response to this collection is required to obtain a benefit(s) required in 25 CFR 20. A Federal Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting for this form is estimated to average 1 hour per response, including the time for reviewing instructions, gathering and maintaining data, and completing the form. Direct comments regarding the burden estimate or any other aspect of this form to: Office of Regulatory Affairs & Collaborative Action - Indian Affairs, Information Collection Clearance Officer, 1849 C Street, NW, MS-3071, Washington, DC 20240.

FEDERAL LAW GOVERNING FRAUD

Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or devise a material fact, or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both.

DECISION

When you file an application for social services, you have a right to a written decision within 30 days. In some cases, it may take 45 days. If you disagree with the decision, you may have a review of the decision by seeing your Human Services worker or supervisor. You also may file an appeal and have a hearing. An applicant or recipient must pursue the appeal process applicable to the Public Law 93-638 contract, Public Law 102-477 grant, or Public Law 103-413 Self-Governance Annual Funding Agreement. The regulations for Human Services are in Title 25, Code of Federal Regulations, Part 20.

The amount of grant assistance you may receive or authorize to be expended is based on State Standards of Public Assistance and/or the rates established by the Assistant Secretary - Indian Affairs, minus your income and available resources. The information you give must be accurate. If your circumstances change, you must report this immediately to your Human Services office. By doing so, your Social Services worker can give you proper assistance you are eligible to receive.

Within the limits of its authority, the Human Services Office wants to help you. Ask your Human Services worker to explain more fully any of this information. If you give inaccurate information and receive assistance to which you are not entitled, you will be required to pay it back.

____

Declaration of No Income

Applicant/Tenant Name: ______________________________

1. I hereby certify that I do not individually receive income from any of the following sources:

   a. Wages from employment (including commissions, tips, bonuses, fees, etc.);

   b. Income from operation of a business;

   c. Rental income from real or personal property;

   d. Interest or dividends from assets;

   e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;

   f. Unemployment or disability payments;

   g. Public assistance payments;

   h. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household;

   i. Sales from self-employed resources (Avon, Mary Kay, Shaklee, etc.);

   j. Any other source not named above.

2. Choose one:

☐ Currently, I have no income of any kind and while I am seeking employment, there is no definite job offer at this time.

☐ Currently, I have no income of any kind and I will not be seeking employment at this time.

My basic living needs (shelter, food, utilities) have been with the assistance of the person indicated below or as described below:

Name: ______________________________ Phone: ______________

Address: ______________________________

I hereby certify the information contained in the Declaration of No Income is complete and accurate to the best of my knowledge. I understand that I am signing this Declaration under Penalty of Criminal Prosecution if I knowingly give false information, which results in assistance being distributed to an individual/family who is not eligible for such assistance.

______________________________ ______________________________

Signature Date