

GENERAL ASSISTANCE PROGRAM

The purpose of General Assistance is to help when an applicant has insufficient resources to meet basic needs. General guidelines are that you must be a tribal member, apply for *ALL State and Federal funding*, i.e. food stamps, TANF (if applicable), commodities, Social Security Income (if applicable), VA Disability (if applicable), etc. *before* applying with the program. Must be low income, and live in Ottawa or Northeast Delaware County. The goal of the General Assistance program is to increase self-sufficiency.

- The applicant must supply us with a Tribal Enrollment Card, driver's license or state I.D., and social security card.
- The applicant must be an *enrolled* member of a Federally Recognized Tribe.
- Applicant must come in person to the Quapaw Family Services Office and obtain and complete an application for General Assistance.
- Each General Assistance recipient must work with the family services worker to develop and sign an Individual Self-Sufficiency Plan (ISP). The plan must outline the specific steps the individual will take to increase independence by meeting the goal of employment.
- The applicant must not receive any comparable public assistance.
- Applicant must actively seek employment, and provide evidence of your monthly efforts to obtain employment.
- If an applicant does not seek and accept available local and seasonal employment, or quit a job without good cause, the applicant cannot receive General Assistance for a period of at least 60 days, but not more than 90 days after they refuse or quit a job.
- There are certain exceptions to the employment policy of which an applicant may receive General Assistance without seeking employment. Please contact a Family Services worker for more information on this policy.
- The head of household who does not comply with the specifications will not be eligible for General Assistance for a period of at least 60 days, but not more than 90 days.
- The application must be filled out completely or it will be returned back to the applicant and that will only delay the process further.
- Please allow at least fifteen (15) working days for approval or denial.
- The application *must* be filled out completely. If the application is not complete, it will be returned back to the applicant, which will only delay the process.
- If there is any fraudulent or omitted information on the application, the applicant could be ineligible for any other programs the Family Services Department offers. Also, according to the 25 CFR Part 20 Subpart F Sec. 20.607, applicants or recipients who knowingly and willfully provide false or fraudulent information are subject to prosecution under 18 U.S.C. 1001, which carries a fine of not more than \$10,000 or imprisonment for not more than 5 years or both.

General Assistance Application

Basic Eligibility Requirements

- Be an enrolled member of a federally recognized tribe/nation
- Live in Ottawa County
- Low income (Schedule of Standard Money Payment for General Assistance)
- Come to the Family Services Department to obtain and complete application IN PERSON

Information Needed to Complete Application

- Tribal Enrollment Card
- Driver's License
- Social Security Card

Notice

Make sure all information is accurate. All fraudulent or omitted information will void an applicant from being eligible for general assistance for one year. This is strictly enforced.

Please allow 15-20 working days for approval or denial!

**U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS
Social Services
Application for Assistance/Services**

NAME: _____ (Last) _____ (First) _____ (Middle) _____ PHONE NUMBER _____

Address and Location: _____

FAMILY PROFILE

Date of Birth

Members of Household	Date of Birth			Sex	Relation to Head of Household	Social Security #	Tribal Enrollment #
	Mo	Day	Year				
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

RECORD OF INCOME AND RESOURCES

Earned _____	General Assistance _____	Burial _____
Unearned _____	Child Welfare _____	Disaster _____
Resources Available _____	Service Only _____	
Total _____		

DECISION

Total Monthly Income _____ Application: Approved Disapproved Date: _____
 State Monthly Standard _____ (Review Dates _____)
 Monthly Amount Needed _____ Caseworker: _____ Date: _____

Statement of Cooperation

I (we) apply for financial assistance for 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.
 I (we) agree to supply information regarding resources and income and to notify the agency of any changes in my (our) situation. Social Services is authorized to obtain information necessary to establish eligibility for assistance.
 I (we) have read, or had explained to us, the provision of our protection under the Paperwork Reduction Act and the Privacy Act.

Client Terminated from TANF past 90 days? Yes No Are you eligible to reapply for TANF? Yes No

Date Signature of Applicant Date Signature of Second Applicant

Enter asterisk (*) at left of name of each person not included in general assistance payment.

NAME (Last)

(First) (MI)

RECORD OF INCOME AND RESOURCES

A. HOME

Owned Value \$ Balance Due \$ Payments \$ per

Rented Rent \$ per Subsidized Unsubsidized

Free Shelter

Type: (please circle correct answer)

Very Poor

Poor

Adequate

Number of Rooms

Source of Water Supply:

B. REAL ESTATE (please circle correct answer)

Total number of acres:

Owned

Assigned

Allotted

Undivided interest:

Is the land operated by family?

Yes

No

If yes, how many acres?

Estimated annual net income from farming &/or ranching?

Is all or part of the land leased?

Yes No

If yes, give number of acres?

Total annual rentals?

Name of Lessees:

C. LIVESTOCK (enter information on Livestock in possession of Family Group)

Kind	Number	Value	Amount Owed	Owed to	Annual Net Income

D. MACHINERY AND/OR EQUIPMENT

Kind	Value	Balance Owed	Name & Address of Creditor

E. AUTOMOTIVE EQUIPMENT

Make	Model	Year	Estimated Value	Monthly Payments	# Payments Due

F. SOCIAL SECURITY INFORMATION

Name of WE or Beneficiary	SS, AN or CN	Entitlement cleared	Amount Benefit

G. PENSIONS AND BENEFITS (Includes Public Assistance and Unemployment Insurance, etc.)

Name of Recipient	Kind of Payment	Amount of Payment

H. VETERANS INFORMATION – MILITARY SERVICE

Name of Veteran	Dates of Service	Branch	VA Claim #	Amount Benefit

I. CASH ON HAND AVAILABLE

Name of Owner	Amount	Depository	Plan for Use

J. INCOME - OTHER SOURCES

Name of Person	Annual Amount	Monthly Available	Source	Plan for Use

K. SUMMATION OF UNDUPLICATED INCOME FOR INCLUSION IN THE ASSISTANCE PLAN:

Earnings:	\$ _____	Rent/Lease:	\$ _____
Earnings:	\$ _____	Pen benefits:	\$ _____
Small Business:	\$ _____	Soc. Sec.:	\$ _____
Cash on hand:	\$ _____	VA:	\$ _____
Other:	\$ _____	TOTAL:	\$ _____

NAME (Last) (First) (MI)

EMPLOYMENT INFORMATION

A. SKILL OR TRAINING

Name	Skill or Training	How Acquired

B. PAST EMPLOYMENT

Name	Type of Work	Dates	Employer's Name & Address

C. CURRENT EMPLOYMENT

Name	Type of Work	Earnings	Employer's Name & Address

D. UNEMPLOYED

Name	From Date	Reason Unemployed

**Quapaw Tribal Family Services
Social Services Referral Form**

_____ **TANF** – Dept. of Human Svcs., 2114 Denver Harnar Dr., Miami, OK – 541-2400

_____ Date

_____ DHS Worker's Signature

_____ **Medicaid** - Dept. of Human Svcs., 2114 Denver Harnar Dr., Miami, OK – 541-2400

_____ Date

_____ DHS Worker's Signature

_____ **Food Stamps** - Dept. of Human Svcs., 2114 Denver Harnar Dr., Miami, OK – 541-2400

_____ Date

_____ DHS Worker's Signature

_____ **Commodities** – Inter-Tribal Council, 114 N. Eight Tribes Trail, Miami, OK – 542-3443

_____ Date

_____ Worker's Signature

_____ **Workforce** – 121 N. Main, Miami, OK – 542-5561

_____ Date

_____ Worker's Signature

_____ **Social Security Income** – 2108 Denver Harnar Dr., Miami, OK- 542-8495

_____ Date

_____ Worker's Signature

_____ **Medicare** – Social Security Office - 2108 Denver Harnar Dr., Miami, OK- 542-8495

_____ Date

_____ Worker's Signature

_____ **Veteran Disability (VA)** – Veterans' Administration Medical Center –
Honor Heights Dr., Muskogee, OK – 888-397-8387

_____ Date

_____ Worker's Signature

_____ **Child Support** – 106 Veterans Blvd., Miami, OK – 800-522-2922

_____ Date

_____ Worker's Signature

.....

Client's Signature

Date

Employment Application Verification Form
Dept. of Social Services
Quapaw Tribe of Oklahoma

Requirements for Completing Job Search Form:

- Applications must be filled out and submitted complete.
- There may only be one job application made in the town of Quapaw.
- There must be three (3) job searches made as well as filing at Workforce.

Date: _____
Company: _____
Address: _____ City: _____ State: _____
Title: _____ Signed: _____
Was an application submitted? _____ Yes _____ No

.....

Date: _____
Company: _____
Address: _____ City: _____ State: _____
Title: _____ Signed: _____
Was an application submitted? _____ Yes _____ No

.....

Date: _____
Company: _____
Address: _____ City: _____ State: _____
Title: _____ Signed: _____
Was an application submitted? _____ Yes _____ No

.....

Client Signature

Date returned to office

Verification of Residence Form
Dept. of Social Services
Quapaw Tribe of Oklahoma

.....
Name: _____

Address: _____
(City) (State) (Zip)

Directions to help locate residence:

Daytime Phone #: _____ Evening Phone #: _____

1. I can verify that the above named person lives in a Mutual Help House at the address listed above.

Date: _____ Authorized Signature: _____

2. Being the Landlord of the above named person, I do verify that the address above is correct.

Date: _____ Authorized Signature: _____

3. Being the Neighbor of the above named person, I do verify that the address above is correct.

Date: _____ Authorized Signature: _____

4. A Home Visit was made to verify address of above named person.

Date: _____ Authorized Signature: _____

5. Verification of above named person's residence is attached: (Utility bill, Mortgage, Etc.)

Date: _____ Authorized Signature: _____

6. I can verify that the above named person is living in My Household at no added expense to him/her.

Date: _____ Authorized Signature: _____

7. I verify that _____, date of birth _____, was a Resident of the _____ Nursing Home on the date of his/her death on _____.

Date: _____ Authorized Signature: _____
.....

CASE PLAN AND INDIVIDUAL SELF-SUFFICIENCY PLAN

Direct Assistance: General Assistance _____ TWEP _____
 Emergency Assistance _____ Disaster Assistance _____
 Burial Assistance _____

.....
Name of applicant/recipient (s):

Address:

Telephone #:

The following regulations of the General Assistance Program are:

- Applicants/recipients have to actively seek employment
- Make satisfactory progress on their ISP
- Accept local and seasonal employment and provide evidence of monthly efforts to obtain employment in accordance with the ISP
- Report any changes which may affect GA eligibility

Non-compliance:

- If the applicant/recipient does not comply with the ISP, an ineligibility period of 60 to 90 days will be imposed.
- If the applicant/recipient refuses or quits a job, the ineligibility period will continue until the applicant/recipient seeks and accepts available local employment and fulfills the obligations agreed to in the ISP

Applicant/Recipient (s) responsibilities are:

The applicant/recipient:

- must participate in developing the ISP and sign this document
- perform successfully in work related activities, community service, training and/or other employment assistance programs developed in the ISP
- participate successfully in treatment and counseling services identified in the ISP
- participate in evaluations of job readiness and/or other testing required for employment purposes
- demonstrate active job search/actively seeking employment by providing the social services worker with evidence of job search activities as required in the ISP

Applicant/Recipient Signature

Date

Caseworker Signature

* Copy of ISP must be provided to applicant/recipient(s) *

CASE PLAN AND INDIVIDUAL SELF-SUFFICIENCY PLAN

Goal (s):

Specific action steps will be made to accomplish the goal (s) identified:

Applicant/Recipient (s) activities/tasks with target dates identified (include short & long range):

- 1)
- 2)
- 3)
- 4)

Caseworker activities/tasks:

- 1)
- 2)
- 3)
- 4)

Progress of applicant/recipient/service recipient:

Satisfactory _____

Unsatisfactory _____

Referrals to other programs were: (Caseworkers must document the outcome of the referral, i.e., was applicant/recipient eligible for those other services and the date of referral)

TANF/FAMILY _____
SSA/SSI _____
VA _____
Food Stamps/Commodity Program _____
LIHEAP _____
UCB _____
GED/AVT/Higher Education _____
Substance Abuse/Mental Health _____
Other _____

CASE PLAN AND INDIVIDUAL SELF-SUFFICIENCY PLAN

Assessment of Employability:

1. Is the client unemployable as defined in 25 CFR 20.315? Yes No
(Provide explanation)

2. Is the client currently unemployed? Yes No

3. Does the client lack job skills? Yes No
(If yes, explain)

What job skills does the client identify? How did the client obtain these skills?

4. What is the last date of employment? Month Year

5. Employment history:

6. Is the client potentially eligible for Unemployment Compensation Benefits?
 Yes No

7. Does the client have a GED or High School diploma?
If yes, year obtained

8. Does client have post secondary education or training? If yes, name of school and year attended, certification or degree obtained:

Client Signature & Date:

Notes:

QUAPAW NATION

P.O. Box 765
Quapaw, OK 74363-0765

(918) 542-1853
FAX (918) 542-4694

RELEASE OF INFORMATION

To be used for release of information from other agencies, etc. to the

QUAPAW NATION

FAMILY SERVICES PROGRAM

OFFICE (918)-238-3152

FAX (918)-238-3332

To whom it may concern:

I hereby give my consent for the agencies listed on the referral, job search and residence form to release information the Quapaw Nation Family Services department, which would be used to my benefit and assistance determining my eligibility for services from Quapaw Nation.

Signature

Address

City

Date

Date of Birth

S.S.#