General Assistance Check List

Medically unable to work

____ Complete Intake

____ I.D.P (Individual Development Plan)

____ Signed Emergency Cash Assistance Policy

____ Tennessan Warning/Data Privacy

____ GED/HIGH SCHOOL DIPLOMA

____ Request for Assistance

____ Photo I.D. (tribal/state/government issued

____ Verification of Enrollment in a federally Recognized Tribe (Tribal I.D. OK)

____ Verification of Residency (Mail, Housing letter, Bill with your name on it)

____ Signed Verification of Income

____ Signed verification of employment

____ New Beginnings Medical Form (completed by a Doctor stating you are unable to work)

____ Food Support Verification (Beltrami County/Food Distribution (Every 3 Months)

____ **ALL Males 18 yrs + ** Must have a Selective Service Number on file. www.sss.gov

______________________________	______________________________
Date Client Enrolled into Program	Date Client Completed Program
______________________________	______________________________
Assigned Case Manager	Date Completed

In Order for your application to be considered or approved, all the items listed must be in file.

CASE MANAGERS HAVE 7 – 10 DAYS TO PROCESS PAPERWORK

OSHKIIMAAJITAHDAH

CLIENT INTAKE INFORMATION

Personal Information   Date of Previous application: _______________ CIF # ______________

Name: ___________________________________ Social Security #: ______________________________

Address: ______________________________________ Phone: _________________________________

______________________________________ Email: ___________________________________

Native American:_________ Tribe: ________________________________ Native Hawaiian: _______

Male: ____ Female: ____ Date of Birth: ________________ Receiving Cash Assistance: ____________

Single adult: ______(age 22 or older)   Youth: _______ (age 21 or under)

Registered with Selective Service: _____________ (all males 18-24 must provide verification)

Family Status

Single person: _______   Head of Household: _______   Total in household: ________

Teen Parent: ________   One-parent family: _________   Two Parent family: ________

List all members of your household (including birthdates)

____

____

____

____

Employment Status

Currently working: Yes: ______ No: ______ Received notice of lay-off: Yes: ________ No: __________

Hourly wage: ______ Current job: _______ or last job: ______ Last date worked: __________________

Education status:

Dropped out of High School: ______   Date: __________   Highest grade completed: ____________

Attending Middle/High School: ________   Current grade level: ________

Attending Post High School: __________   Course of Study: ______________________________

High School Diploma or GED: __________   Date Received: _______________________________

Employment History

List of jobs you have had in the past:

1.) Job Title: ________________________________ Employer: ________________________________

Responsibilities: ____

Skills used: ____

Date Hired: __________________________________ Date job ended: ___________________________

2.) Job Title: ________________________________ Employer: ________________________________

Responsibilities: ____

Skills used: ____

Date Hired: __________________________________ Date job ended: ___________________________

3.) Job Title: ________________________________ Employer: ________________________________

Responsibilities: ____

Skills used: ____

Date Hired: __________________________________ Date job ended: ___________________________

Volunteer Work: ____

Job Related Training

First Aid Card: Y ___ N ___ Date: _________________ CPR Training: Y ___ N ___ Date: __________
Permits: ____
Union Members: Y ___ N ___ Name: ____
Work Shops/Training attended:
Title: _______________________________________ Date: ____
Title: _______________________________________ Date: ____

Education History

Attended Post High School in the past: __________ Date: ____

School: _____________________________________ Grad? Y ___ N ___ Credits earned: _______________

Course of Study: ____

Currently attending GED: ___________ Vocational School: _____________ College: ___________________

Name and Location of School: ____

Certificate or Degree Program: ____

Estimated completion date: ____

Other Educational Information: ____

Personal Information Checklist: (circle your answer Y for yes, N for no)

1. Transportation is a hardship Y N ______________________________
2. Driver's License Y N ________________________________
3. Need child care services Y N ________________________________
4. Receiving housing assistance Y N ________________________________
5. Criminal history is a barrier to employment Y N ________________________________
6. Currently under doctor's care Y N ________________________________
7. Are you able to work? Y N ________________________________
8. Substance abuse issues Y N ________________________________
   - Are you able to pass a drug test? Y__ N ___
9. Do you have trouble communicating Y N ________________________________
10. Reading level is low Y N ____________ Math level is low Y N ____________
11. Other difficulty (ies) relating to school, employment or training Y N ___________________

Personal and/or Family Income

Source	Monthly Income	Date Started	Date Ended
MFIP (TANF)			
Social Security Inc.			
General Assistance			
Unemployment Ins.			
Housing Assistance			
Child Care Assist.			
Food Stamps			
Child Support			
Wages			
Other			
Total Monthly Income:			

CERTIFICATION: I certify the information given is true to the best of my knowledge. I understand that the information provided is subject to review and verification and I may have to provide documents to support this intake. I am also aware that I am subject to termination for six (6) months if I am found ineligible after enrollment and maybe be prosecuted for fraud and/or perjury. I agree to supply information regarding resources and income and will notify Oshkiimaajitahdah of any changes in my (our) situation. This authorization is to disseminate employment and educational information to potential employers and educational institutions for the purpose of assisting me in obtaining assistance, training, education or employment.

______________________________________ ______________________________________

Signature of Applicant/Date Signature of Parent/Legal Guardian/Date

CERTIFICATION:

Certain education, employment and training programs available through Oshkiimaajitahdah require applicants to undergo drug screening. I understand that I may be required to undergo a drug-screening test at any time prior to commencement of training or supported work service. I also understand that a positive test result, or refusal to cooperate fully with the drug-screening procedure, will result in denial of financial assistance through Oshkiimaajitahdah for training and supported work services.

____ ____

Signature of Applicant/Date | Signature of Parent/Guardian/Date

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CERTIFICATION FOR ELIGIBILITY FOR SERVICES

I certify that this individual has met the application requirements and based on all information received through the intake interview process; this person is eligible for 102-477 services.
The determination is based on the Employment Barriers and the following criteria:
Native American _______ Unemployed _______ Econ. Disadvantaged _______ TANF Recipient ______ (Child/Adult)

____ ____

Case Manager Signature/Date | Reviewer Signature/Date

Primary Activity: ____

Immediate goal: __________________________________ Target Date: ____________________________

Goal #2:____ Target Date: ____________________________

Goal #3: ____ Target Date: ____________________________

Goal #4: ____ Target Date: ____________________________

ACTIVITY COMPLETION:

Primary Activity: __________________________________ Completion Date: ________________________

Activity #2: ______________________________________ Completion Date: ________________________

Activity #3: ______________________________________ Completion Date: ________________________

Activity #4: ______________________________________ Completion Date: ________________________

Date of Completion: _________________________ Completed other plan objective: ________________

Completed Education/Training Objective: _________ Other Completion: __________________________

Revised 04-2013

INDIVIDUAL DEVELOPMENT PLAN

Name: ______________________________   Date: ______________________________

GOALS

(Sometimes you can use your short-term goals to help you reach your long-term goals. Long-Term goals of becoming a doctor, for example, require fulfilling many short-term goals first. For example, you may need to get a job with a flexible schedule to allow you to study for your medical school entrance exams. Getting a flexible job, therefore, is a short-term career goal that will help you reach your long-term goals.)

Long Term/Short-Term	Date Achieved

ASSETS AND BARRIERS

BASIC MATH AND LANGUAGE SKILLS

JOB SKILLS AND EXPERIENCE

EDUCATION TRAINING BACKGROUND

WORK BEHAVIORS

PHYSICAL CONSIDERATIONS

FOLLOW UP DATES:

30 DAY FOLLOW UP ______________________ COMMENTS: _________ (See Case Note)_____

60 DAY FOLLOW UP ______________________ COMMENTS: _________ (See Case Note)_____

90 DAY FOLLOW UP ______________________ COMMENTS: _________ (See Case Note)_____

WHAT ARE YOUR SUPPORTIVE SERVICE NEEDS?

I HAVE BARRIERS THAT ARE KEEPING ME FROM FINDING A JOB/HOLDING A JOB OR FURTHER MY EDUCATION. MY BARRIERS ARE:

THE WAYS IN WHICH I WILL HELP REMOVE THE BARRIERS ARE BY:

TO HELP ME ACHIEVE MY GOALS THE SUPPORTIVE SERVICE I NEED ARE:

CASE MANAGER SUMMARY:

CERTIFIED STATEMENT

I clearly understand and agree with the Plan on Services as written. My signature below verifies that I actively took part in the planning process.

______________________________	______________________________
Signature of Client/Date	**Signature of Case Manager/Date**

Red Lake Band of Chippewa Indians – Oshkiimaajitahdah

Emergency CASH ASSISTANCE POLICY

CERTIFICATION

The Case Manager will have up to **ten (10) business days** determine eligibility once the client completes all required documentation.

If a client resigns or is terminated from suitable employment they **are ineligible** for emergency cash assistance for **a thirty (30) day** period from the date the required documentation is complete.

Eligibility is determined by the case manager and when all proper documentation is completed and in the file. The maximum amount per single adult individual is $203.00 per month. The maximum amount per two person family would be the same as the state TANF rate with is $276.00 per month.

If an eligible client is incarcerated or in a half-way house they are ineligible for cash assistance because their basic needs are being met. Cash assistance is meant for temporary assistance to meet the basic needs of a client while they are unemployed or waiting for a response for disability or social security.

Cash assistance checks must be picked up by the person whose name is on the check. No exceptions!

Clients who appear to be intoxicated will be asked to leave the building and will not be able to pick up their check until they do not appear intoxicated. If a check **is not picked up within five (5) business days from issuance,** the check will be voided and the client will have to reapply.

DEFINITIONS

- A single head of household is considered a single individual with an active light bill in their name.
- A two person family is considered individuals who are married or common law Husband and Wife.
- Any time a family unit will be eligible for emergency cash assistance will be when they have received their 60 month lifetime limit under TANF. Each member must have verification of enrollment.
- An individual who is medically unable to work must have an Oshkiimaajitahdah health examination form signed by a qualified professional stating the individual is medically unable to work for a minimum of 1 to 3 months.

REQUIREMENTS

The following documentation must be provided along with a completed intake/application, signed cash assistance policy form, and self-sufficiency plan.

JOB SEEKING

- Head of household
- Signed copy of emergency cash assistance policy
- Active light bill
- Tribal identification
- Verification of food support – Beltrami County or
- Verification of food distribution Commodity program – Redby.
- Verification of job search signed by an authorized company representative.

MEDICALLY UNABLE TO WORK

- Health examination form signed by a qualified professional
- Tribal identification
- Verification of food support – Beltrami County or
- Verification of food distribution Commodity program – Redby.

RECERTIFICATION

Recertification is done every three (3) months. The client must provide same information as if they are reapplying for job seeking or medical services.

MUTUAL EXPECTATIONS

WHAT YOU AGREE TO DO:

- Ask questions when you do not understand something.
- Work as hard as you can to go to work or attend training to support work activities.
- Show up on time for activities or call ahead if you can't make it.
- Tell us when there is a problem that interferes with work or training.
- Follow your employment plan as agreed.
- **Not to call the Tribal Accounting department on the status of your check. They are allowed up to three (3) business days to process a check.**

WHAT WE AGREE TO DO:

- Listen as you tell us about yourself, your family and your program in moving to work.

- Promptly return your phone calls.
- Possibly help you with transportation expenses, or work clothes – please state in your Individual Development Plan.
- Help you find the resources you need to get and keep a job.

I understand this certification and concur with my signature.

______________________________	______________________________
Applicant Signature/Date	Case Manager/Date

TENNESSAN WARNING/DATA PRIVACY

DATA PRIVACY RIGHTS FOR APPLICANTS/RECIPIENTS OF THE OSHKIIMAAJITAHDAH PROGRAM

YOUR RIGHTS:

Under the Minnesota Data Privacy Act, you have the right to know how the information you provide on your application will be used. The information you provide on the application for a program is classified as private under Minnesota law and cannot be disclosed without your permission, except as provided below.

PURPOSE AND USE:

The information on the application will be used to determine your eligibility for the program and level of assistance. Information you provide will also be used for statistical and research purposes and will not reveal any personal identifying information and you or members of your household.

WHAT IS REQUIRED?

We encourage you to answer all the questions because your correct answers will enable us to properly verify and prioritize your application. Emergency phone, language spoken in your home, township, and number of persons employed in the household, race years of education and child's schools are optional. However, this information is requested for the purpose of you. Your response will not affect consideration of your application. By providing this information, you will assist us in assuring that this program is administered in effective non-discriminatory manner. Number/code/status blanks are for office use only. We may not be able to properly process your application without all other information.

WHO WILL HAVE ACCESS:

Tribal staff and county, state (federal) employees, whose job requires access to your application as well as auditors, may have access to your application. These people are all required not to disclose any personal information about your or members of your household. State and/or federal employees and auditors may review applications to ensure that the Oshkiimaajitahdah programs are serving properly.

The Oshkiimaajitahdah system for collecting and utilizing personal participate data is limited to facilitate efficient administration of the program, while simultaneously safeguarding the privacy of its subjects. As mandated by Minnesota Government Data Practices Ace of 1974, the program has established a system for data management methods and procedures outlined below.

TYPES OF DATA MAINTAINED:

The following type of data may be contained in the applicant files. This is compilation of data requested on all forms by this program, and collectively required by funding purposes.

1. Name
2. Social Security Number
3. Tribal affiliation
4. Medical reports and information to relative to Employment and Training
5. Psychological reports relative to Employment and Training
6. Home Telephone number
7. Home address
8. Household income
9. Age
10. Sex
11. Housing situation (own, rent..)
12. Number of persons in household
13. Names and relationship of household members
14. Handicap
15. Nature and dollar amount of assistance received
16. Copies of bills submitted for reimbursement
17. Source of income
18. Substance abuse history relevant to employment and training
19. Criminal and traffic violations relevant to employment and training
20. Date of enrollment
21. Past/present work history
22. Veteran status
23. Educational levels
24. Participation in other programs relative to employability, planning and funding.

RECORDS RETENTION:

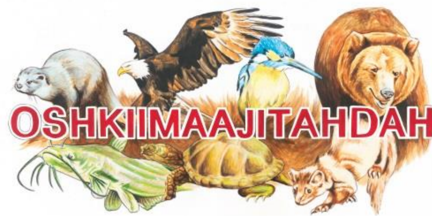
a. All past and present participant records will be reviewed quarterly.
b. At no time will any employee of Oshkiimaajitahdah collect data on or maintain a private file on Any participant of the program.

SECURITY:

Participant files are stored in locked cabinets located in the Oshkiimaajitahdah Central File Room and are under lock at all times. A request for the key to gain access to the file room will be made to Security or the Executive Director. Program staff are responsible for the program files, its contents and the Executive Director and the Security Guard will be responsible for the internal and external access and security.

Verification of client being informed of the Tennessan Warning is indicated by his/her signature below.

______________________________	______________________________
Signature of Applicant/Date	Signature of Case Manager/Date



Request for Assistance

Name: ____ Date: ______________________

Current Address: ____
(Box #) (Phy. Address) (Town) (State) (Zip)

Maxis/CIF #: _________________ PH: __________________ Message PH: ______________

Email: ____ District: __________________

Brief description of the assistance you are requesting: ___________________________________

Estimated Cost Requested: __________________________ Name of Vendor: _______________

I certify that the information provided herein true to the best of my knowledge. I am aware that the information is subject to review and I may have to provide documentation to support this request. I am aware that I may be subject to prosecution for fraud and/or perjury if statements contained are found false.

__________________________________ Signature of Applicant

__________________________________ Signature of Case Manager

FOR OFFICE USE ONLY:

Eligibility Determined: YES NO Complete File: YES NO Compliance: YES NO

_______ Approved _______Disapproved: Reason: ______________________________

Request reviewed by: ___________________________________ Date: _________________
(Compliance Manager)

Request reviewed by: ___________________________________ Date: _________________
(Executive Director or Authorized Employee)

Account Payable:

- ○ **102-477**
- ○ **MFIP**
- ○ **DWP**
- ○ ______________
- ○ **Auto Insurance** **Drivers Education** **Auto Repair** **Drivers License Fee**

  Clothing

  Other; Specify ____________________________

OSHKIIMAAJITAHDAH

15525 Mendota Ave, PO Box 416 Redby, MN 56670
(218)679 3350

REQUEST FOR CERTIFICATION OF TRIBAL ENROLLMENT

I give the Tribal Enrollment Office permission to certify my
Tribal Enrollment / Membership Information for Oshkiimaajitahdah

Applicant Please Print Clearly

Name: ____
First M.I Last

Date of Birth: _____________________/_____________________/_______________________________

Complete Address: ____

____

Affiliated Tribe: ____

____
Signature/Date

TO BE COMPLETED BY THE TRIBAL ENROLLMENT DEPARTMENT ONLY

(______) Is an enrolled member of the Red Lake Band of Chippewa Indians

(______) Is an enrolled member of ____________________________________
(Print Affiliated Tribe)

(______) Is not an enrolled member, according to our enrollment records

I certify the above information is to be true and correct. This information is take from the membership rolls of the Red Lake Band of Chippewa Indians or other Federally Recognized Tribe.

____ ________________________
Certifying Official/Enrollment Department Date

This form may be faxed back to Oshkiimaajitahdah (218) 679-3202
Staff Requesting Verification: _________________________________

OSHKIIMAAJITAHDAH

RELEASE OF INCOME

I hereby authorize the following Business/Program to release my earnings/wages for the prior 3 months. This is being requested to determine eligibility for services.

____ ____________________________
Print Name of Client **Social Security Number**

____
Signature of Client

Name of Employer ____

Address ____

This section is to be completed by the Employer:
The income for the above names individual is as follows:

For the month of:	For the month of:	For the month of:

The above named individual is currently not employed and his/her last date of employment was on ________________________.

____ ____________________________
Signature of Authorized Employee Date

This section is to be completed by Oshkiimaajitahdah Staff:

The income for this client for the past 3 months is ____.

Multiplied by 4 to annualize is ____.

In accordance with the intake the client household size is: _________________________________.

Based upon income and LLSIL poverty guidelines, I declare this client to be Eligible ____ Ineligible ____.

____ ____________________________
Signature of Authorized Staff calculating eligibility Date

Revised: 7/13 Please return to: Oshkiimaajitahdah, ATTN: ________

Red Lake Band of Chippewa Indians Employment & Training

VERIFICATION OF EMPLOYMENT

I hereby authorize the following information be released to the Red Lake Band of Chippewa Employment & Training, Oshkiimaajitahdah to determine eligibility for services and assistance.

______________________________________ ______________________________________

Print Name Date of Birth

______________________________________ ______________________________________

Signature/Date Social Security Number

TO BE COMPLETED BY AUTHORIZED COMPANY REPRESENTATIVE

Company Name: ____

Address: ____

____

Phone Number: ___________________________ Job Title: _________________________________

Date started: _____________________________ Last Date of Employment: ___________________

Hourly Salary: __________________

Type of employment:
Permanent: __________ Full-time _________ Temporary: _________ Part-time: _________

If temporary, state estimated length of employment: ___________________________________

Employee will/has receive their first check on ______________ for ____________ hours.
Date Amount

Company Official: ____
Signature/Date

____
Name/Title

Please complete and return to: ATTN: ________________________
Oshkiimaajitahdah, 15525 Mendota Ave,
PO Box 416, Redby, MN 56670
Phone 218-679-2477 Fax: 218-679-3202

Oshkiimaajitahdah
Release of Information
Health Examination Form

I, ____authorize the following information to be released to Oshkiimaajitahdah to determine eligibility for assistance/supportive services.

____
Signature & Date

The following should be completed & signed by your primary physician

---

Physician Name: ____

Address: ____

Phone Number: ____

Patient's Complaint: ____

____

Diagnosis: ____

____

Patient's ability to perform gainful employment: ___Employable ___Not employable

Recommendations for treatment as prescribed by physician: ____________________________

____

Has the patient adhered to prescribed therapy? ___Yes ___No

Approximate length of incapacity: ___One Month ___Two Months ___Three Months

Can the patient be employable with treatment? ___Yes ___No

____
Physician Signature & Date

Please mail the original form to Oshkiimaajitahdah, P.O. Box 416, Redby, MN 56670

Attention:____

If you have any questions regarding this form please call (218) 679-2477 or fax our office (218) 679-3202

INCOMPLETE FORMS WILL NOT BE CONSIDERED, PLEASE COMPLETE THE ENTIRE FORM

THANK YOU