



Supportive Service Packet

- _____ Complete Intake
- _____ I.D.P (Individual Development Plan)
- _____ Request for Assistance
- _____ Photo I.D. (Tribal/State/Gov't issued)
- _____ Verification of Residency
- _____ Verification of Enrollment (Federal Recognized)
- _____ Verification of Income
- _____ Verification of Employment
- _____ Tennessee Warring/Date privacy
- _____ Food Support Verification from Beltrami County
- _____ ** ALL males 18 + years must have a Selective Service # on file. www.sss.gov
- _____ Job Search (If applying for bus card only)

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

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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	_____
o 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

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: _____

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



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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 _____

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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

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 you 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 Act 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 Tennessee Warning is indicated by his/her signature below.

Signature of Applicant/Date

Signature of Case Manager/Date

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Job Search Contacts

I hereby authorize the information be released to the Red Lake Band of Chippewa Indians, Oshkiimaajitahdah to determine eligibility for services and assistance. I also understand that one job search site must include Red Lake Gaming within a 3 month period. All employment search activities are subject to verification.

Print Name

Signature

TO BE COMPLETED BY AUTHORIZED COMPANY REPRESENTATIVE

Date of Contact (Mo/Day/Yr)	How did you apply: __Application/Resume __Inquiry POSITION: _____ __In person Other (describe): _____	Employer: _____ Contact: _____ City: _____ Phone/fax: _____ Interview was given: _____ If online – website or email Address: _____
Date of Contact (Mo/Day/Yr)	How did you apply: __Application/Resume __Inquiry POSITION: _____ __In person Other (describe): _____	Employer: _____ Contact: _____ City: _____ Phone/fax: _____ Interview was given: _____ If online – website or email Address: _____
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Date of Contact (Mo/Day/Yr)	How did you apply: __Application/Resume __Inquiry POSITION: _____ __In person Other (describe): _____	Employer: _____ Contact: _____ City: _____ Phone/fax: _____ Interview was given: _____ If online – website or email Address: _____

I initial this Job Search Log to state that all information is accurate and correct. I understand that falsifying information can make me ineligible for services with Oshkiimaajitahdah. ____/____(Client initials/Date)