COOK INLET TRIBAL COUNCIL
People. Partnership. Potential.

Cook Inlet Tribal Council
Employment Training & Services Department
APPLICATION FOR SERVICES

Email this application to elg@citci.org

Fax this application to 907-793-3394

Questions? Call us at 907-793-3300

WHAT KIND OF HELP DO YOU NEED? *PLEASE CHECK ALL THAT APPLY*

Cook Inlet Tribal Council delivers the following services: / For State of Alaska services please check below.

☐ Tribal Temporary Assistance (TANF) ☐ BIA General Assistance ☐ Child Care

☐ Employment Services ☐ Supportive Services ☐ Youth Services

☐ COVID Assistance ☐ HPOG (Health Professional Opportunity Grant)

☐ Heating Assistance (LIHEAP) (pays a portion of home heating costs)

☐ I am out of fuel or have a disconnect notice for within 48 hours (attach copy of disconnect notice to this application)

☐ Subsidized Rental Housing Utility Deposit (SRHUD)
helps pay a utility deposit when households are moving into Section 8 or subsidized rental housing, provided that heat is included in rent.

☐ Weatherization (pays a portion of home heating system modifications & repairs

State of Alaska Services:

☐ Food Stamp

☐ Adult Public Assistance : ☐ blind or disabled or ☐ elderly assistance

☐ General Relief: ☐ Rent/Utilities or ☐ Burial

☐ Health Insurance (includes Medicaid, Denali Care, Denali KidCare, tax credit, private health insurance)

☐ Chronic & Acute Medical

INFORMATION ABOUT YOU:

Name		Social Security Number	Other Names Used
Marital Status: Circle One	Registered for Selective Service?	Veteran?	Email Address

Regional Corporation Affiliation:
Type S= Shareholder F= Family Member D= Descendant of

____Ahtna ____Aleut ____ASRC ____BSNC
____BBNC ____Calista ____Chugach ____CIRI
____Doyon ____Koniag ____NANA ____Sealaska
____13th Regional ____None

Alaska Native Ethnicity:
____Aleut ____Alutiiq ____Athabascan
____Haida ____Inupiat ____Siberian Yup'ik
____Tsimshian ____Yup'ik/Cup'ik ____Don't Know
____Tlingit ____Eyak

Home Address or Directions to Your Home	City	State	Zip
Mailing Address	City	State	Zip

Home Phone:
Cell Phone:
Work Phone:

Emergency Contact:
Name:
Phone: Email:

Answer these questions to see if you get food stamps within seven days.

1. Is cash and money in bank $100 or less? ☐Yes ☐No
2. Is your household's 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

SIGN HERE:	**Date:**

NOTE: If more space is needed, please attach another piece of paper.

INFORMATION ABOUT YOU AND THE PEOPLE WHO LIVE WITH YOU *PLEASE PRINT*

Name First M.I. Last	Relation to you If not related write NR.	Birth Date And Born in Alaska?	Sex M-Male F-Female	Provide the information requested below for the people for whom you want benefits.		Education Level	Ethnicity (Optional) Hispanic Or Latino?	Race (Optional) Select one or more: AN - Alaska Native AI - American Indian AS - Asian BL - Black/African-Am C - Chinese F - Filipino J - Japanese K – Korean S - Samoan PI - Native Hawaiian/ Pacific Islander V - Vietnamese WH - White
				Social Security Number	U.S. Citizen Or National?	Write in highest grade completed in school, Vocational School, or College Degree		
	Self							AN☐AI☐AS☐ BL☐PI☐WH☐_____
								AN☐AI☐AS☐ BL☐PI☐WH☐_____
								AN☐AI☐AS☐ BL☐PI☐WH☐_____
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								AN☐AI☐AS☐ BL☐PI☐WH☐_____

Note: Disclosure of your Race and Ethnicity information is voluntary and will not affect your eligibility or level of benefits. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.

1. Has anyone received or is expected to receive money from a job or self-employment? ☐ Yes ☐ No *If yes, complete the information below.*

Person Employed/Start Date/Schedule (ex. M-F 8-5)	Employer/Phone Number	# hours worked	hourly wage	how often paid?
		/week		
		/week		
		/week		

2. Has anyone began or expecting to begin a training program or School? ☐ Yes ☐ No *If yes, complete the information below.*

Training/Educational Institution	Course of Study/Schedule (ex: Mon-Fri, 8-5 pm)	Trainer/Advisor/Phone #	Start Date	End Date

3. Has anyone received or is expected to receive any money from any other sources (not including income listed above)?

☐ None
☐ Tribal Temporary Assistance/ATAP
☐ BIA General Assistance
☐ Child Support or Alimony
☐ Veteran's Benefits
☐ Worker's Compensation
☐ Interest
☐ Alimony
☐ Pension/Retirement
☐ Education Financial Aid
☐ Social Security Income
☐ Seasonal Employment *(must complete additional form)*
☐ Foster Care Payments
☐ Cash outs of Retirement or Pension
☐ Unemployment
☐ Rental Income
☐ Support From Others
☐ Student Loans/Grants
☐ Adult Public Assistance Program
☐ Adoption Subsidy Payments
☐ Other: _____

For the checked items above, please fill out the below information (Proof must be attached to the application)

owner/source/amount	owner/source/amount	owner/source/amount

4. Do you have any of the below items?

☐ None
☐ Annuities
☐ Burial Policy Agreement
☐ Cash on Hand
☐ Certificate of Deposit
☐ Checking Account
☐ College Savings Plan
☐ Commercial Fishing Permit
☐ IRA Account
☐ Life Insurance Policy
☐ Mineral Rights
☐ Native Corporation Shares
☐ Pension Plan
☐ Retirement Funds
☐ Safe Deposit box
☐ Savings Account
☐ Stocks/Bonds
☐ Trust Funds
☐ Other_____

For the above checked items please fill out the below

Who Owns the Item?	**Type of Item**	**Where Held**	**Account Number**	**Total Value/Balance**

5. List any land or buildings, fishing permits, stocks, bonds, or other items of value owned by you or anyone in your household.

owner	type of property/asset	value	owner	type of property/asset	value	owner	type of property/asset	value
		$			$			$
		$			$			$

6. List all vehicles owned by you or anyone in your household (cars, trucks, motorcycles, boats, RVs, snowmobiles, etc.).

owner	type of vehicle/model	year	how is vehicle used?	value	amount owed
				$	$
				$	$
				$	$
				$	$

7. Have you moved to Anchorage in the last 3 years? ☐ Yes ☐ No

8. Do you own or rent your home? ☐ Own ☐ Rent ☐ Stay w/Relatives ☐ Homeless

9. Do you pay for your home heating costs? ☐ **Yes** ☐ **No**

10. List how much your family pays each month for rent/mortgage and utilities.

Rent/Mortgage Amount: $

Utilities Amount: $

11. Does anyone in your household pay for child care or dependent care expenses? ☐ Yes ☐ No

amount $

12. Does anyone in your household pay child support? ☐ Yes ☐ No

If yes, who?

amount $

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

If yes, who? *When is baby due?*

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

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

16. 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? *If yes, who?* ☐ Yes ☐ No

17. Child Support Cooperation Section: TANF Applicants only fill out Questions 17-22

Child's Full Name	State Child Born In	Absent Parent's Full Name	Is there a court custody order	Are both Parents on Birth Certificate
			☐Yes or No ☐	Yes ☐or No ☐
			☐Yes or No ☐	Yes ☐or No ☐
			☐Yes or No ☐	Yes ☐or No ☐
			☐Yes or No ☐	Yes ☐or No ☐
			☐Yes or No ☐	Yes ☐or No ☐

18. Non-Custodial Parent Date of birth:
_____

19. Non- Custodial Parent occupation:_____

20. Does the non-custodial parent have medical insurance for the children? ☐Yes ☐ No

21. Non-Custodial Parents Place of Birth:
_____

22. Address:_____

City/State/Zip_____

Child Support Cooperation and 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 or Tribe any child/spousal support or medical support owed to you for any months 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 Service Division (CSSD). You must do this even if no support order is 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.

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 case worker 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 Cook Inlet Tribal Council 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_____

If you are not applying for medical assistance, skip questions 17-20.

***17.* Is anyone in your household eligible for personal or employer-provided health insurance, Public Health Service, Indian Health Service, TRICARE, 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

***18.* 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

***19.* Does anyone in your household have unpaid medical bills from the last three months?** ☐Yes ☐No

If yes, who? *What months?*

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

If yes, who? *Date of the accident*

If you are not applying for childcare assistance, skip questions 21-27.

***21.* Does anyone in your household pay Health Insurance Premiums (Medical, Vision, Dental only)** ☐Yes ☐No

***22.* Do your assets exceed $1,000,000?** ☐Yes ☐No

***23.* Do you have a shared custody schedule?** ☐Yes ☐No

***24.* Do any of the children in your household have special needs requiring additional services while in child care?** *If yes, additional documents will be requested.* ☐Yes ☐No

***25.* Mode of Transportation** *½ hour of travel time to and from childcare is permitted.*

☐People Mover ☐Own Transportation ☐Other:_____

***26.* Does anyone in your household receive Native Corporation Dividends?** ☐Yes ☐No

*If yes, who and how often?*_____

The first $2000 per household member, per calendar year, is excluded from countable household income. Attach year-to date verification for each family member, from each corporation.

27. List all children within your household for whom you are requesting childcare assistance and have legal custody. Child care may ONLY be used while parents are in their approved activities. Providers must be Licensed or Approved through the State of Alaska and registered with this program before an authorization and payment can be issued. Please make sure your provider will accept CITC Child Care Assistance before applying for your child(ren).

Name of Child	Name of Child Care Provider	Expected Start Date
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		

Please circle providers name above if the registration fee is needed.

If you are not applying for heating assistance or weatherization, skip questions 28-34.

28. **Are you or anyone in your household:** ☐ Legally Disabled ☐ Age 60 or over ☐ Receiving Public Assistance ☐ N/A

29. **Have you or any of the adults in your household applied for Heating Assistance from the State of Alaska (SOA) Heating Assistance Program?** ☐ Yes ☐ No

**if "yes," stop here. You cannot receive Heating Assistance from both the SOA and Tribal or Native organization*

30. **Are there any other individuals living with you at this residence who are not listed as part of your household on pg. 2 of this application?** ☐ Yes ☐ No

If yes, list the names of roommates or other individuals living at this residence and describe how rent and utility expenses are shared.

_____

_____

_____

31. **If your household income does not cover your basic living expenses, explain how you are paying these costs.**

Rent:_____

Utilities:_____

Food:_____

32. Questions about your residence

Please note: all questions on this page need to be completed or your application will be considered incomplete and processing will be delayed.

What type of housing do you live in? Check the below box that applies

☐ Apartment of Condominium: ☐ House ☐ Van or Car* ☐ Pick-Up Camper* ☐ Renting a Room ☐ Cabin
☐ Duplex 2 units ☐ Studio/Efficiency ☐ Group Home ☐ Tent* ☐ Motel/Hotel/Hostel* ☐ Boarding Home*
☐ Triplex 3 units ☐ Travel Trailer (less than 35 feet) ☐ Mobile Home (35 Feet or longer) ☐ Boat
☐ 4 of more units *Lean-to attached* ☐ *Yes* ☐ *No*

**If you live in temporary housing, provide a signed statement from someone who can prove that you have lived there for 60 consecutive days.*

A. If you live in a trailer or mobile home 35 feet or longer, what is the exterior Length:_____ ft. and Width:_____
B. How many bedrooms are in your home? (A loft counts as one bedroom)_____
C. How much rent or mortgage do you pay each month? Rent: $_____ Mortgage: $_____ Space Rent: $_____
D. Is your rent based on 30 percent of your income (Subsidized or Section 8)? ☐ *Yes* ☐ *No* *if you answered yes, attach a copy of your rental housing worksheet and utility allowance worksheet (obtained from your housing agency)*
E. We may need to contact your landlord or manager to get information to process your application.
Name of Landlord:_____ Address:_____ Phone:_____

33. Questions about your heating and electric

A. What is your main heat source? (Check only one. If you have more than one, check the one you use the most)
☐ Natural Gas ☐ Fuel Oil ☐ Electricity ☐ Kerosene ☐ Coal ☐ Propane ☐ Wood ☐ Other:_____
B. If you heat with wood, do you harvest it yourself? ☐ Yes ☐ No
C. Who pays for your home heat? ☐ Self ☐ Landlord ☐ Other *(if other please explain)* _____
D. Who pays for your electricity? ☐ Self ☐ Landlord ☐ Other *(if other please explain)* _____
E. If you pay both heat and electricity, should part of your grant be sent to your electric account? ☐ Yes ☐ No
- Attach copies of your most recent fuel statement, electricity bill, or wood vendor receipts
- If heat is included in your rent, attach a copy of your rental agreement and most recent rent receipt or a statement from your landlord showing heat is included in your rent.

34. Questions about your fuel and/or electric company

A. _____
Name of Fuel Company Account Number Name on Account Amount of Current Bill
B. _____
Name of Electric Company Account Number Name on Account Amount of Current Bill

C. If your account for fuel or electric is in someone else's name, please explain:_____
_____
_____

AUTHORIZED REPRESENTATIVE

I have asked the below listed person to help with my public assistance case.

☐ **I understand that an additional Authorized representative form will be filled out during my interview for services.**

Name of Person _____ Phone/Message Number _____

ALTERNATE

Do not complete this section if you do not want someone else to receive or spend your Tribal Temporary Assistance or Food Stamp assistance.

I want this person to be able to receive and spend my Tribal Temporary Assistance or Food Stamp benefits on behalf of my household.

Which assistance? ☐ Cash ☐ Food

Name of Person _____ Phone/Message Number _____

Address _____ City _____ State _____ Zip _____

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 the food stamps to buy guns, rifles, traps, fuel, ammunition, or clothing.

Signature of Applicant or Other Adult Household Member _____ Date _____

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, income, resources, property, 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 descripted in the "Your Rights and Responsibilities" document during the program interview.

Signature of Applicant _____ Date _____ Signature of Other Adult Applicant _____ Date _____

Signature of Other Adult Applicant _____ Date _____ Signature of Other Adult Applicant _____ Date _____

Signature of Fee Agent or Helper _____ Date _____ Signature of Witness if Signed with an "X" _____ Date _____

PARTICIPANT APPEAL (cash assistance programs only)

If you disagree with an action taken by the CITC Employment and Training Services Department which may affect your cash assistance, you may file an appeal within 30 days of the action. During the 30 days of your appeal date, you may continue to receive cash assistance *if* you request it in writing until a CITC agency appeal decision is made. If the appeal decision is not in your favor, you will be responsible to pay back any extra cash assistance you received while awaiting the appeal decision.

CITC CLIENT GRIEVANCE

If you disagree with the services offered, or the way you are treated, you must follow the client grievance procedure outlined in CITC Policy #3.100. The first step in either an appeal or grievance is to contact the staff with whom you have a complaint to attempt to resolve the disputed action. If you are unable to resolve the disputed action with the staff, you then meet with the staff's supervisor who will work with you to resolve the complaint. For a grievance, if your complaint remains unresolved, you then provide a written complaint within 30 days of event that caused the grievance to the CITC CRP Officer at 3600 San Jeronimo Drive, Anchorage, AK 99508 who will work with you until a solution has been reached.

CHANGES IN HOUSEHOLD CIRCUMSTANCES

You must report changes in your household within 10 days of when you learn of the change. You may do this by contacting the CITC ETSD office by phone, in person or in writing. Reporting changes such as income and resources or changes in your household to other agencies **does not exempt** you from reporting changes to CITC ETSD. You are required to report the following changes:

1. 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.
2. Changes in the source of unearned income and changes in the amount of total unearned income greater than $50.00 per month (Examples: Social Security or Unemployment).
3. When someone moves into or out of your home (If a child is/or going to be absent it must be reported **within 5 days**).
4. If you change your residence or get a new mailing address; we need to verify your new shelter costs if you move or we cannot use them in calculating your cash assistance.
5. If your household gets a vehicle, sells a vehicle or sells any other item to obtain cash.
6. If your household has more than $2000 in cash or money in bank accounts.
7. Changes in your legal obligations to pay child support.
8. Childcare- if changing providers, you must notify our office and you must comply with your provider's policies.
9. Please report any other factors you think may affect your case or eligibility for the services.

WORK/SCHOOL REQUIREMENTS

Tribal Temporary Assistance for Needy Families (TANF) and General Assistance (GA) are Work First Services. To receive services you may have to participate in work activities. TANF and GA participants must meet with their case worker and develop a 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. If you are employed and voluntarily reduce your hours, income, or quit your job without good cause and do not have approval from the case worker, a job quit penalty may be applied to your case. If you are an unmarried minor parent, to receive Tribal TANF you must live with a parent or in another approved living arrangement and attend school or training. If you have school age children they must be enrolled, attending school and making progress. Failure to provide school attendance and grade verification reports may result in a penalty being applied to your case. If you do not fulfill these work and education requirements, or minor parent requirements your cash assistance may be reduced or ended.

HOME VISITS

A CITC Compliance Officer may visit your home unannounced between 7:00 am to 8:00 pm to verify all information reported. Cooperation with the Compliance Officer is required. If you do not cooperate with the Compliance Officer home visit, your TANF, GA, Child Care or Heating Assistance case will close. A Case Worker and Eligibility Technician may also conduct a regular home visit. These home visits are scheduled with you or you are given 10 days' notice prior to the visit. It is in your best interest to cooperate with these home visits. If there is no cooperation, your

assistance could be reduced or closed.

FRAUD PENALTY WARNINGS/OVERPAYMENTS

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or attempt to receive cash assistance, supportive services, or other services through ETSD that you may not be eligible for, or to help someone else receive ETSD services for which they are not eligible for. By accepting services, you understand and agree that you may have a responsibility of repayment of any services or cash assistance you wrongly received caused by yourself or CITC staff.

WARNING: Any information you provide to any CITC program may be used against you in a Court of Law or for implementing an Administrative Disqualification Hearing which will result in an Intentional Program Violation disqualification from the above-mentioned services.

If you misrepresent your residence or identity to receive multiple services to include cash assistance, you can be barred from receiving Tribal TANF for 10 years. Other penalties may also apply.

EMPLOYMENT & SUPPORTIVE SERVICES

If your cash assistance case closes due to earnings, you may still be eligible for other services to help your family become self-sufficient. Please contact the CITC ETSD office for more information.

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 TANF 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 TANF must be reported and turned over to the CITC Tribal TANF office 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: While on TANF If you believe you have a good reason not to cooperate with CSSD, you must tell your eligibility technician or case manager immediately. You may be asked to provide information to support your reason.

When you apply for Tribal Temporary Assistance you must:

- Sign over to CITC Tribal TANF, your right to receive and keep child support payments due to you or to a child on Tribal TANF.
- Cooperate with CSSD by providing information to establish paternity, help locate an absent parent, and enforce a child support obligation.
- Non-cooperation with CSSD or failure to turn over to CITC payments received from CSSD can result in a penalty applied to the case, payee or case closure.

AMERICANS WITH DISABILITIES ACT OF 1990

Cook Inlet Tribal Council, Inc. complies with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the CITC Corporate Affairs Officer at (907) 793-3407.

SOCIAL SECURITY NUMBERS

You must provide or apply for a social security number for yourself and each household members for whom you are seeking assistance from CITC Tribal TANF (42 CFR 435.910). CITC will use social security numbers to access information from the Social Security Administration data system.

SPENDING POLICIES FOR TANF/GA SERVICES: Under Federal Law (section 4004(c) of P.L. 112-96) it is illegal to make purchases with or to access cash assistance on EBT cards/gift cards at any bars, liquor stores, marijuana stores, gambling or adult entertainment establishments. If you fail to abide to this policy a payee may be required.

I certify that I have read and understand the entirety of this document

Signature of Participant	Date	Signature of Other Adult	Date

Cook Inlet Tribal Council, Inc.

Client Grievance Policy Acknowledgement Statement

I have read and been briefed on the CITC Client Grievance Policy and Procedures. I fully understand my rights and responsibilities as a CITC Program Recipient.

Client Signature:

Date:

Distribution: One copy to the Client and the original form for the CITC Office File.

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COOK INLET TRIBAL COUNCIL

REQUEST FOR CONTACT PERSONS AND ORGANIZATIONS

We often need to contact persons or organizations that can verify your situation to determine your program eligibility. When we contact these persons or organizations, we tell them our name, title, and that we work for Cook Inlet Tribal Council's ETSD Programs. We are prohibited by law from telling them anything about you or about your CITC Case.

The information we most often need to verify is where you live, who lives with you, and your household's income and resources and absent parent information.

Please provide the information requested below:

NAME OF SOMEONE WHO KNOWS YOU WELL _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

NAME OF SOMEONE WHO KNOWS YOU WELL _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

NAME OF LANDLORD _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

FINANCIAL INSTITUTION (BANK, CREDIT UNION) _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

EMPLOYER _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

******FOR INTERNAL USE ONLY*** THIS FORM IS NOT TO BE SENT OUTSIDE OF CITC/ANJC/CSELC/GOTNV**

Cook Inlet Tribal Council, Inc. / Alaska Native Justice Center / Clare Swan Early Learning Center / Get Out the Native Vote
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907)-793-3600; Fax (907)-793-3423

Authorization to Release Personal Information Within CITC and Related Entities[1]

Participant's Name: _____ DOB: _____ Month/Day/Year Last four digits of SSN: _____

☐ Participant ☐ Parent ☐ Legal Guardian authorizes CITC and related entities to:

_____ (Initial) Release protected health and other information as indicated below. **Please mark any records to be shared within CITC and related entities**.

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. I understand that although this ROI provides CITC and related entities with the authority to release my information within CITC departments and related entities, CITC policies require that only the minimum necessary information be released for the provision of services. Other specifications, if any:

_____

_____

Psychotherapy Notes, as defined by HIPAA, CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records. Nothing listed on this ROI is considered Psychotherapy Notes.

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION RELEASED: (circle and initial all that apply)

W / E / V ____Admission Summary
W / E / V ____Application for Services
W / E / V ____Attendance/Progress Report
W / E / V ____Career Development Assessment
W / E / V ____Discharge Status
W / E / V ____Education Assessments*
W / E / V ____FAS/FASD Assessments
W / E / V ____Health History/Physical Records
W / E / V ____Household composition
W / E / V ____Housing
W / E / V ____Immunization Records
W / E / V ____IT/legal/accounting
W / E / V ____Income and Wages
W / E / V ____Lab Reports (OCS and PO)
W / E / V ____Legal History
W / E / V ____Medication Records
W / E / V ____Medication Records–Substance Abuse
W / E / V ____Psychiatric Evaluation
W / E / V ____Psychological Evaluation
W / E / V ____Psychosocial History
W / E / V ____Service Plan (non-clinical)
W / E / V ____Supportive Services
W / E / V ____Treatment Plan (clinical)
W / E / V ____Treatment Recommendations for Level of Care (residential or outpatient)
W / E / V ____Other(specify) _____

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies, information covered by the Violence Against Women Act (VAWA), and other information through Q and/or Parent Connect and other resources between CITC and related entities and ASD, and within CITC and related entities. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time**._____(initial)

1. I understand that: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.
2. I understand that: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization, I must do so in writing and present my written revocation to CITC for PHI records, and in writing *or orally for substance use disorder treatment records;* (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

   Unless otherwise revoked, this authorization will expire on the following date:_____. If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.
3. I understand that my alcohol and/or drug treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and its enacting regulations, and that, depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. *I understand that only health information covered by 42 C.F.R. Part 2 (i.e., alcohol and drug use or treatment) will continue to be protected by law from redisclosure once it leaves CITC*. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records that are subject to HIPAA cannot be disclosed by CITC or related entities beyond what is permitted under this authorization, without my written consent unless provided for by regulation.
4. I understand that information covered by VAWA may be disclosed and understand the type of information, reason for sharing and potential recipients.
5. ☐ _____ **(Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**

   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

Signature _____ **Date** _____

Signature of Guardian/Parent/Authorized Person _____ **Relationship to Participant** _____ **Date** _____

Printed Name _____

Signed copy received by participant: ☐ ____Yes (init) ☐ _____No, participant declined copy. (init)

Billing Entities potentially receiving information: AETNA; Affiliated Computer Services, Inc(Medicaid); AK Pipe Trade Local 367 Health and Security; AK Electrical Health and Welfare Fund; AK HERE Health and Welfare Trust; AK Rural Employee Benefit Trust; Alaska Labors; Alaska U.C.F.W.Trust; Ameriben/IEC Group; ASEA/AFSCME Local 52 Health Benefits Trust; Blue Cross Blue Shield; Chanlyut; First Choice Health PPO Plan; Great West Health Care; Health and Welfare Benefits System; Healthcomp; Maritain Health; ODS Select Network Group; PGBA/Tricare; Principal Financial Group; Providence Health Plan; PS5 Health Plan Solutions; Risk Benefits Management Services; Salvation Army; SOAK Carpenters Health & Security Plan; SOA Office of Children's Services; American Postal Workers Union Health Plan; Zenith Administrators

Family Educational Rights and Privacy Act (FERPA):
This Authorization to Release Personal Information within CITC is governed by The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 C.F.R. Part 99), which protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education, including the Anchorage School District.

[1] "CITC and related entities" include the Alaska Native Justice Center, Inc. (ANJC), Clare Swan Early Learning Center (CSELC), and Get Out the Native Vote (GOTNV)

Cook Inlet Tribal Council, Inc.
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907)-793-3600; Fax (907)-793- 3423

Authorization for CITC to Obtain Personal Information

Participant's Name: DOB: (Month/Day/Year) Last four digits of SSN:

☐ Participant ☐ Parent ☐ Legal Guardian authorizes Cook Inlet Tribal Council (CITC) to:

_____ (Initial) obtain protected health and other information as indicated below.

The participant's signature below authorizes CITC to obtain protected health information and personal information from the following organization(s).

Name: _____
(Facility, Organization, or Individual Name)

Address: _____ Phone/Fax: _____

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. I understand that although this ROI provides CITC with the authority to release my information, CITC policies require that only the minimum necessary information be released for the provision of services. Other specifications or special conditions, if any:

_____

_____

Psychotherapy Notes CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION RELEASED: (circle and initial all that apply)

W / E / V ____Admission Summary
W / E / V ____Application for Services
W / E / V ____Attendance/Progress Report
W / E / V ____Billing Information
W / E / V ____Career Development Assessment
W / E / V ____Discharge Status
W / E / V ____Education Assessments
W / E / V ____FAS/FASD Assessments
W / E / V ____Health History/Physical Records
W / E / V ____Housing
W / E / V ____Immunization Records
W / E / V ____Income and Wages
W / E / V ____Lab Reports (OCS and PO)
W / E / V ____Legal History
W / E / V ____Medication Records
W / E / V ____Psychiatric Evaluation
W / E / V ____Psychological Evaluation
W / E / V ____Psychosocial History
W / E / V ____Service Plan (non-clinical)
W / E / V ____Treatment Plan (clinical)
W / E / V ____Other(specify)

_____

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies and other information through Zangle and other resources between CITC and ASD, and within CITC. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time**._____(initial)

1. I understand: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.

2. I understand: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and in writing or orally for substance use disorder treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

   Unless otherwise revoked, this authorization will expire on the following date: 10/2/2020**.** If this space is left blank**, this authorization will be presumed to expire two (2) years after the signature date below.**

3. I understand my alcohol and/or drug treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA) and its enacting regulations and, that depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. I understand that only health information covered by 42 C.F.R. Part 2 (*i.e.,* alcohol and drug use or treatment), will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand my records cannot be disclosed by CITC beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

4. ☐ _____ **(Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**
   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

Signature **Date**

Signature of Guardian/Parent/Authorized Person **Relationship to Participant** **Date**

Printed Name

Signed copy received by participant: ☐____Yes (init) ☐_____No, participant declined copy. (init) **CITC Employee Initials:**_____

ANCHORAGE SCHOOL DISTRICT
CONSENT FOR RELEASE OF EDUCATION RECORDS
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF EDUCATION RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records created or maintained by a school that receives federal funds. Completion of this document authorizes the disclosure and use of education records as described below. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

STUDENT INFORMATION:

Student Name: _____ Date of Birth: _____

Social Security Number: _____ Grade: _____

School: _____

Parent/Legal Guardian Name: _____

Relationship to Student: _____

USE AND DISCLOSURE INFORMATION:

I, the undersigned, do hereby authorize _____

(*name of agency or educational institution maintaining records*)

to disclose and deliver the complete education records maintained under the above student's name including but not limited to the following:

* Grades and transcripts
* Psychological & Educational testing
* Verbal Information
* School health records
* Special education records
* Discipline

***Please list any records you do not wish to be disclosed*: _____

The education records described above shall be delivered to:

Name: _____ Organization: _____

Address: _____

City/State/Zip Code: _____ Telephone Number: _____

PURPOSE:

This information is to be disclosed and used for the purpose of:

☐ Special Education Evaluation & Planning
☐ § 504 Evaluation & Planning
☐ Provision of Special Education Services
☐ Information for School Nursing
☐ Other _____ (*please provide explanation*).

AUTHORIZATION FOR REDISCLOSURE:

Under federal law, the requestor (School District) may not redisclose the information identified above to any other party without your prior consent. If you wish to authorize the School District to redisclose the information identified above please mark the box below:

☐ I authorize the School District to redisclose the education information described above and I understand that if the information is redisclosed it may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

My authorization for the use, disclosure and/or redisclosure of the information identified above is voluntary. I understand that the information to be disclosed or redisclosed may include individually identifiable health information. I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me.

_____ Date: _____

Signature of Student's Parent or
Student's Legal Guardian

Relationship: _____