SOCIAL SERVICE PROGRAMS

Quechan Indian Tribe

Fort Yuma Indian Reservation
P. O. Box 1899
Yuma, Arizona 85366-1899
Phone (760) 572-0201
Fax (760) 572-2099

The goal of the General Assistance program is to increase self-sufficiency. Each General Assistance recipient must work with the Eligibility 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. Listed below are the documents requested to complete a household application

- ◻ Turn in proof of tribal enrollment for each individual listed in household
- ◻ Turn in social security cards for each individual listed in household
- ◻ Turn in birth certificates for each minor listed in household
- ◻ Proof of residence – Any mail, ***Lease***, Utility Bill or letter from owner
- ◻ Verification of ALL public assistance and income each individual listed in household receives (If denied for TANF) (TANF Denial needed)
- ◻ Develop and sign an Individual Self-Sufficiency Plan (ISP)
- ◻ Complete a Quechan Direct Assistance application

To submit documentation:

Mail: Quechan Indian Tribe
P.O. Box 1899, Yuma, AZ 85366
Fax: (760) 572-2099
ATTN: Direct Assistance Program

We are urge you to update your information with your local postal service. The U.S. Postal Service will not place any check(s) in a P.O. Box if you are not listed on the box holder(s) account. The Quechan Social Service will not be responsible for incorrect mailing addresses.

Office: Monday - Friday 8:00 AM to 5:00 PM

Email: Electronic Signature is provided, and all parties agree that forms may be electronically signed. The parties agree that the electronic signatures appearing on any form from the Quechan Social Services Department are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility. All electronic mail (e-mail, fax) are not confidential and can be intercepted and read by other people

Eligibility Worker, Marissa Miller
sseligibilityworker@quechantribe.com

Data Entry Clerk, Michael Miguel
ssdataentryclerk@quechantribe.com

IN REPLY REFER TO:

United States Department of the Interior
BUREAU OF INDIAN AFFAIRS
Washington, DC
1849 C Street, NW
Washington, DC 20240
(202) 513-7673

INTERVIEW DATE: ________________

APPLICATION FOR FINANCIAL ASSISTANCE AND SOCIAL SERVICES INSTRUCTIONS

Any individual or family may apply for Bureau of Indian Affairs Financial Assistance and Social Services by completing the application process with the assistance of the Social Services worker and providing the following required information: proof of Tribal membership; proof of residency; proof of income and resources. Failing to provide this information may result in denial of Financial Assistance and Social Services.

DIRECTIONS FOR COMPLETING "APPLICATION FOR FINANCIAL ASSISTANCE AND SOCIAL SERVICES" FORM
Please fill in your Name, Tribe, and Phone Number(s). Please provide your Physical Address/Mailing Address (if different from physical address) or provide directions on how to get to your residence. Please also respond to the two questions.

Section I: FAMILY PROFILE OF HEAD OF HOUSEHOLD MEMBERS APPLYING: Under Family Profile, fill in the following information to the best of your ability. First, start with yourself. Fill in your name (Last, First, Middle), Date of Birth (mm/dd/yyyy), Sex (M/F), your marital status, the highest education level received, Social Security Number, and your Tribal Enrollment Number. Next, complete the names of the total members of the household starting with your spouse and then children in descending order of age. For each member, list the birth date, sex, and relation to the head of household, marital status, highest education received, Social Security Number, and Tribal Enrollment number. If you are living in a household with more than one (1) family, list the family members that fall under your household.

Section II: TYPES OF FINANCIAL ASSISTANCE AND SOCIAL SERVICES: Put a check mark in the boxes for the services you are applying. This will assist your Social Services worker in determining which portions of the application you will need to complete.

Section III: EARNED & UNEARNED INCOME: All income, including earned and unearned income, for yourself and any other person in your household, is to be listed on the application. The timeframe for calculating earned and unearned income amounts is the months (30 days) received (25 CFR §20.307). You are required to provide proof of income.

Earned Income is cash, or any in-kind payment earned in the form of wages, salary, commissions, or profit by an employee or self-employed individual. This includes one-time payments for ongoing activities such as sale of crops or sale of artwork. Self-employed individuals must report profits from business enterprises (gross receipts minus business expenses included in the production of goods or services). Business expenses do not include depreciation, personal transportation costs, capital equipment purchases or principal payments on loans for capital assets or durable goods. (25 CFR §20.308)

Unearned Income includes but is not limited to; interest, royalties, gaming income or other per capita distribution not excluded by federal statue, rental property, cash contributions, retirement benefits, annuities, veteran's disability, unemployment benefits, and tax refunds. Other types of unearned income include financial assistance from government agencies, income from sale of trust land or other real or personal property set aside for investment in trust land that has not been reinvested in trust land or a sale of a primary residence that has not been reinvested in a primary residence at the end of one year from the date the income was received, and in-kind contributions providing free shelter up to the 25% of the amount for shelter included in the state standard. (25 CFR §20.309)

Under Section II and Section III, please complete questions 1-4 to the very best of your ability based on the information provided above. If you are unsure of the question, please ask your Social Services worker for assistance or clarification.

Section IV: STATEMENT OF COOPERATION: The Statement of Cooperation is a confirmation of your understanding of the provisions of the Federal Law governing fraud, and you agree to supply information regarding resources and income and to notify the agency of any change in your living situation. Also, you must sign the Release of Information authorizing the Social Services Program to obtain and/or exchange information necessary to establish eligibility for Financial Assistance and Social Services.

IF YOU NEED CLARIFICATION OR HAVE ANY QUESTIONS, PLEASE ASK YOUR SOCIAL SERVICES WORKER

NOTIFICATION TO THE CLIENT

PRIVACY ACT STATEMENT

25 CFR Part 20 and 25 U.S.C. 13 authorize the collection of this information. The information is confidential and is never disclosed without written clearance and consent of the applicant. The primary use of this information is to determine eligibility for financial assistance and services for the Bureau of Indian Affairs (BIA) Child Welfare, Burial and Disaster Assistance Programs. Additional disclosures of this information may be to other BIA or tribal officials in the conduct of their official duties pertaining to the application for financial assistance or services, or in the conduct of program review and to the Office of Inspector General or the General Accounting Office when conducting an audit of BIA Programs, or local Law Enforcement agency when the agency becomes aware of violation or possible violation of civil or criminal law, and to the General Services Administration in connection with its responsibility for records management. This information will be entered into the BIA, Financial Assistance and Social Services – Case Management System, Interior/BIA-8 (76 FR 56787), which can be obtained upon request from the Chief, Division of Human Service, 1849 C Street, N.W., MS-4513-MIB, Washington DC 20240. No record contained therein may be disclosed by any means of communication to any person, or to another agency, except pursuant to a written request by, or with prior written consent of the individual to whom the records pertains. Executive Order 9397 authorizes the collection of your Social Security number. Furnishing the information is voluntary but failure to do so may result in disapproval of your application. If the BIA uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

Under the Privacy Act, BIA may not give out information you give the social service worker except that BIA may share the information with other Federal, State, and Tribal offices and programs who have some responsibility with the social services for which you are applying. The information can also be given to those agencies when you ask them for a job or some other benefit and for law enforcement purposes. This can be done without your consent. For any other person or program wanting information from your case file, you must first give your written consent. You have the right to know what information is in your case record and you can ask to see it. If you believe some information in your case file is inaccurate, ask your caseworker about how to change the information in the case record.

FEDERAL LAW GOVERNING FRAUD

Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or devise a material fact, or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined, imprisoned not more than 8 years, or both.

PAPERWORK REDUCTION ACT STATEMENT

This information is being collected to determine applicant eligibility for financial assistance and services and to provide Bureau of Indian Affairs (BIA) managers with information for program planning, reporting and utilization. Response to this collection is required to obtain benefits under 25 CFR 20. A Federal Agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Public reporting for this form is estimated to average 30 minutes per response, including the time for reviewing instructions, gathering and maintaining data, completing the form. Direct comment regarding the burden estimate or any other aspect of this form to: Information Collection Clearance Officer, Office of Regulatory Affairs & Collaborative Action – Indian Affairs, 1849 C Street, N.W., MS-3071-MIB, Washington, D.C. 20240.

DECISION

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

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

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

ELIGIBILITY

INDIAN BLOOD (***25 CFR §20.100)***

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

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

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

ELIGIBILITY FOR OTHER SERVICES

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

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

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

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

REPORTING REQUIREMENTS

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

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

IMPORTANT: Once you have finished reading the *Notification to the Client*, you must initial that you have read and understand all provisions of the Notification to the Client; read and understood the Statement of Cooperation; and read, understood, and signed the Release of Information. You must then sign and date Page 3 of the Application.

Appointment Date and Time: ________________________

CLIENT INFORMATION SHEET

Date: ________________ Time In: ________________

What Direct Assistance Program are you looking to request assistance from?

□ General Assistance □ Child Care Assistance □ Emergency Assistance

□ Adult Care Assistance □ Burial Assistance

Name: ________________________________ Tribe/Enrollment #: ___________________

Other Name(s) Used: ______________________________ Phone Number: _______________

Email: ____ Fax: __________________________

Address: ____

City: ________________________ State: ___________________ Zip Code: _____________

What is the best way to stay in contact with you?

□ Email □ Mail_____________________________ □ In Person

Client understands that electronic mail (e-mail,fax) are not confidential and can be intercepted and read by other people.

FAMILY PROFILE OF HEAD OF HOUSEHOLD MEMBERS APPLYING

Member of Household (Last, First, Middle)	Date of Birth M/D/Y	Sex (M/F)	Relation to Head of Household	Social Security Number	Tribal Enrollment Number
1.			Self		
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

13.THIS AREA IS FOR BIA AGENCY USE ONLY

Social Service Worker Initial: _______ Date/Time: __________

APPOINTMENT DATE/TIME : ___________________

Comments:____

____

LINE ITEM APPROVAL:

OMB Control No. 1076-0017
Expires: 03/31/2024

BIA Form # 5-6601
Revised: 02/17/2021

U.S. Department of the Interior
Bureau of Indian Affairs
Division of Human Services

Date of Application: ______________________

Date of Interview: ______________________

Decision:

☐ Approved; Date: _______ to _______: _______ Initials

☐ Denied; Date: ____________: _______ Initials

Reason for Denial:

Date of Redetermination _________ / _________

APPLICATION for FINANCIAL ASSISTANCE and SOCIAL SERVICES

SHADED AREAS ARE FOR BIA AGENCY USE ONLY.

Name (Last, First, Middle): ________________________________ Tribe: ________________________________

Other Name(s) Used: ________________________________ Home Phone Number: ________________________

Physical Address: ________________________________ Cell Phone Number: ________________________

Mailing Address (if different from physical address): ________________________________

Directions on how to get to your home (if no physical/mailing address): ________________________________

Reason for applying for Financial Assistance and Social Services?

Section I: FAMILY PROFILE OF HEAD OF HOUSEHOLD MEMBERS APPLYING (25 CFR §20.308)

Fill in all required blanks for everyone who lives with you, either permanently or temporarily. **You must list** yourself first, then your spouse and children, then other adults and children. BIA employees will place an asterisk (*) to the left of each person not included in payment.

Members of Household Name (Last, First, Middle)	**Date of Birth**			**Sex** (M/F)	**Relation to Head of Household**	**Marital Status** (Married, Single, Widowed, Divorced, Common Law, Separated)	Highest Grade/ Degree Completed	**Social Security Number**	**Verified**	**Tribal Enrollment Number**	**Verified**
	Month	**Day**	**Year**								
1.					Self						
2.											
3.											
4.											
5.											
6.											
7.											
8.											

Section II: TYPES OF FINANCIAL ASSISTANCE AND SOCIAL SERVICES (Check type of Assistance or Services applying for)
[Items with an asterisk (*) require BIA Line Officer Approval & Signature; Cost-Sharing for Foster Care or Adoption Subsidy requires BIA Line Officer Approval &Signature]

A. ☐ **General Assistance**

D. ☐ **Burial Assistance**

E. ☐ **Emergency Assistance**

G. ☐ **Information & Referral Only**

B. Child Assistance
- *☐ Foster Care
- *☐ Residential Care
- *☐ Adoption Subsidy
- *☐ Guardianship Subsidy
- ☐ Special Needs
- *☐ Homemakers Services

C. Adult Care Assistance
- *☐ Homemakers Services
- *☐ Residential Care/ Group Home

F. Services-Only
- ☐ Child Protection
- ☐ Adult Protection
- ☐ Child & Family Services
- ☐ IIM Services

Section III. EARNED INCOME & UNEARNED INCOME (25 CFR §20.308-§20.310)

Is anyone in the household currently working or have they worked in the past 30 days? ☐ Yes ☐ No

If yes, identify Household Member(s) who are working and their earnings:

Household Member # 1 Name: ______________________ Amount: $ ________ Frequency: ______________

Household Member # 2 Name: ______________________ Amount: $ ________ Frequency: ______________

Household Member # 3 Name: ______________________ Amount: $ ________ Frequency: ______________

Do you expect to receive or are receiving any of the following listed below: ☐ Yes ☐ No

(If yes, put a check mark in the box in front of all unearned income (not from employment) received by any household members, (see box below; use additional space for further explanation.)

Earned Income		Unearned Income	
☐ Alimony/ Child Support	Amount: $	☐ Supplemental Security Income (SSI)	Amount: $
☐ Gifts/ Contributions	Amount: $	☐ TANF	Amount: $
☐ Income Tax Refund (Federal/State)	Amount: $	☐ Food Stamps	Amount: $
☐ Insurance Settlement (Auto Accident, etc.)	Amount: $	☐ Commodities	
☐ Interest/ Dividends (Bank Accounts) Other (list):	Amount: $	☐ Foster Care Payments	Amount: $
☐ Lease Income (list)	Amount: $	☐ Other (list) (Example: Carl Perkins P.L. 105-332)	Amount: $
☐ Lottery/ Gaming Income (cash winnings)	Amount: $	☐ Other (list) (Example: Alaska Native Corporation Dividend	Amount: $
☐ Retirement Benefits/ Pensions	Amount: $	Explain the Amount Approved and/or Disapproved- need to specify gross and net earnings. (Social Service Worker Section)	
☐ Royalties	Amount: $		
☐ Tribal Per Capita Payments	Amount: $		
☐ Social Security/ Survivor/ Disability Benefits	Amount: $		
☐ Unemployment Benefits	Amount: $		
☐ Veteran's Benefits/ Payments	Amount: $		
☐ Worker's Compensation Benefits	Amount: $		
☐ Farm/ Ranch Income	Amount: $		

Have you applied for TANF? ☐ YES ☐ NO Date: ____________

Have you been terminated from TANF past 90 days? ☐ YES ☐ NO

Are you eligible to reapply for TANF? ☐ YES ☐ NO

Have you applied for other Resources/ Programs? ☐ YES ☐ NO Date: ____________

Section IV. STATEMENT OF COOPERATION

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

Under 18 U.S.C. §1001, the Federal Law concerning fraud states: "[W]hoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact; makes any materially false, fictitious, or fraudulent statement or representation; or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both."

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

Please initial: Read & Understood the Statement of Cooperation: _______
Read & Understood the Notification to the Client: _____
Read, Understood, & Signed the Release of Information: ______

__________ Date ______________________ Signature of Applicant #1 __________ Date ______________________ Signature of Applicant #2 (If Applicable)

__________ Date ______________________ Social Services Worker Signature __________ Date ______________________ BIA Line Officer (If Applicable)

United States Department of the Interior

BUREAU OF INDIAN AFFAIRS

RELEASE OF INFORMATION

You grant and authorize the exchange of information between the BIA/ Tribal Human Services Program and the following agencies/programs:

Tribal/State Employment Offices
Tribal/State Social Services Programs
Social Security Administration
Tribal/State Education Programs
Tribal/State/Federal Courts
Tribal/State Medical Services
Tribal Enterprises
Alaska Native Corporations
State/County Fiduciary Trust Offices

Tribal/State Alcohol & Drug Programs
Tribal/State Housing Programs
Veteran's Administration
Tribal/State Federal Probation Programs
Tribal/State Child Protection Services
Tribal/State Mental Health Services
Tribal/State Voc-Rehab Programs
Indian Health Services

Other (specify): ______________________________

Other (specify): ______________________________

Any information exchanged will pertain to your eligibility to receive Financial Assistance and Social Service benefits or referral to other programs that would benefit you. By signing on the statement of cooperation (Page 3 of the Application) you agree and understand any information obtained will be kept confidential and will be used only for the purposes directly connected with providing benefits or services on your behalf. You further agree and understand that any information obtained may be released to proper governmental agency, court, or law enforcement agencies for purposes of legal and investigative action concerning fraud.

This Release of Information will remain in effect for one (1) year from date of signature or until you request to rescind authorization.

I authorize the Social Services Program to obtain and/or exchange information necessary to establish eligibility for Financial Assistance and Social Services.

______________________________ ____________ ______________________________
Name of Applicant (Print) Date Signature of Applicant

OMB NO. 1076-0017
EXP: 03/31/2024
BIA 5-6602

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS

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

Date GA Recipient met ALL goals (mm/dd/yyyy) (mm/dd/yyyy)/ Initials: ______/______/______ / _________

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

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

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

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

Short-Term Goals:

Long-Term Goals:

BARRIERS TO CLIENT

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

STRENGTHS OF CLIENT

Identify strengths the client possesses:

STEPS NEEDED TO ACHIEVE SELF-SUFFICIENCY

WORK ACTIVITIES

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

EDUCATION/ TRAINING

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

OTHER ACTIVITIES

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

CASE PLAN

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

SELF SUFFICIENCY ACTION PLAN & GOALS

GOAL #1

Goal #1 Revised

ACTION STEPS FOR GOAL #1	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

GOAL #2

Goal #2 Revised		

ACTION STEPS FOR GOAL #2	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

SOCIAL SERVICES WORKER'S ACTIVITY WITH TIMEFRAME (25 CFR 20.318)	DATE TO BE ACHIEVED	DATE COMPLETED
1.		
2.		

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS

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

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

________ ____
Date Signature of Applicant

________ ____________________________________
Date Signature of Social Service Worker

________ ____________________________________
Date Signature of Bureau Line Office (if applicable)

Privacy Act Statement

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Paperwork Reduction Act Statement

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☐ Not applicable

G. INFORMATION & REFERRAL ONLY

DATE	NARRATIVE