Physical location:
2640 West Point Rd.
Green Bay, WI 54304
Mailing: P.O. Box 365
Oneida, WI 54155

ONEIDA

Telephone:
920.490.3939
1.800.216.3216
fax: 920.490.6803
www.oneida-nsn.gov

Application for General Assistance

All applicants must provide the following information:

☐ Copy of Tribal Identification Card
☐ Proof of residence **– Must live in Brown/Outagamie Co.**
☐ Verification of income in the last 30 days
☐ Lost Employment Due to COVID-19
☐ Verification of pending claim
☐ Individual Self Plan
☐ Medical Examination Capacity Form
(If unable to work due to health issues)

APPLICANT INFORMATION				
LAST NAME	FIRST NAME	MI	DOB	SSN

MAILING ADDRESS	UNIT#

CITY	STATE	ZIP

PHYSICAL ADDRESS	UNIT#

PHONE NUMBER	TRIBAL AFFILIATION	ENROLLMENT #

MARITAL STATUS	ARE YOU A VETERAN?	HIGHEST GRADE COMPLETED

REASON FOR APPLYING FOR GENERAL ASSISTANCE

INDICATE IF COVID RELATED (IE: JOB LOSS, COMPANY CLOSED, HOURS DECREASED, FURLOUGH, ECT)

LIST ALL HOUSEHOLD MEMBERS & INCOME TYPE (EARNED OR UNEARNED)

Full Name	DOB	Relationship	Income Type	Monthly Amount	Tribal Affiliation

EARNED INCOME & UNEARNED INCOME			
Check mark all your earned and unearned income received			
EARNED INCOME		**UNEARNED INCOME**	
☐ Wages/Salary **Employer:**	$	☐ Social Security Income	$
☐ Child Support/Alimony	$	☐ TANF	$
☐ Gifts/contributions	$	☐ Food Stamps	$
☐ Settlements	$	☐ Commodities	$
☐ Interest/Dividends	$	☐Foster Care Payments	$
☐Rental Income	$	☐ Other:	$
☐ Lottery/Gaming income	$		
☐ Tribal Per Capita	$		
☐Unemployment	$		
☐Veteran's Benefit	$		
☐ Workers Compensation	$		
☐ Other:	$		

Have you applied for disability? ☐Yes ☐No Date:_____

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
List: _____

BUDGET CALCULATIONS		
# of Adults:	# of Children:	Total Household Size:

What are your monthly essential expenses?

Shelter/rent: $_____
Utilities: $_____
Food: $_____
Clothing: $_____

Total Monthly Expenses: $_____

GENERAL ASSISTANCE STATEMENT OF UNDERSTANDING

It is the responsibility and requirement as the applicant to provide all required documentation with this application and complete all areas of the application. If the application is incomplete or missing documentation, it will be returned and denied.

Before the Bureau of Indian Affairs can give social services help, it must gather information about you and your family. The authority which authorized the Bureau to provide such help and to ask for the needed information is in the Act of Congress passed on November 2, 1921. It is published in Title 25 of United States Code at Section 13 and is usually called the Snyder Act. The only information you need to give is what is necessary for social services to decide if you qualify for help and that is the main purpose it will be used for.

Under the Privacy Act 5 U.S.C. 552(a) Section 7(a)(1)(2), social services cannot give out the information you give the caseworker with the exception being other Federal, State, Tribal offices and programs who have some responsibility with the social service for which you are applying. The information can also be given to those agencies when you ask them for a job or for some other benefits and for law enforcement purposes. This can be done without your written consent. For any other person or program requesting information from your case record file, you must first give your written consent. You have a right to know what information is in your case record and you can ask to see it. If you believe some information is inaccurate, ask your caseworker about how to change the information in the case record.

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 request a review of the decision by seeing your caseworker or their supervisor. You also may file an appeal and have a hearing. The policy for social services is in Title 25 of the Code of Federal Regulations at Part 20 and in Part 66 of the Bureau of Indian Affairs Manual.

The amount of grant assistance you may receive is based on state standards of public assistance less your income and resources. The information you provide must be accurate. If your circumstances change, you must report this to your social services office. In this way, social services can give you the proper assistance you are eligible to receive.

On the other side of this form is a copy of the application you completed for social services and it contains the majority of information used to decide your eligibility for social services.

Within limits of the authority, the social services program wants to help you. Ask your caseworker for more fully explain any of the information given above. If you give inaccurate information and receive assistance to which you are not entitled, you must pay it back.

The Federal Law concerning fraud states…"Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsified, conceals or covers up by any trick, scheme or device a material fact, or makes any false fictitious or fraudulent statements or representations or makes or uses any false writing or documents, knowing the same to contain any false fictitious or fraudulent statement or entry will be fined not more than $10,000 or imprisoned not more than five years or both."

General Assistance grants and monthly grant amounts are subject to change based on funding availability.

I certify that the responses I have given to the above questions and statements are to the best of my knowledge accurate, truthful, and without omission.

_____ _____

Applicant Signature Date

Office use only
Interviewed by: _____ Date:_____

ECONOMIC SUPPORT SERVICES
PO BOX 365
ONEIDA WI 54155

MEDICAL EXAMINATION & CAPACITY FORM

Name	Date of Birth	SSN

Name of Professional Provider	Professional Title
Office Address	City, State, Zip Code

The individual named above has applied for General Assistance, this form indicates that he/she has temporarily or permanently impaired by metal and /or physical deficiency, disability, illness, or injury. Making it close to impossible to secure employment. Thank you for taking the time to complete this form. We look forward to providing the best individualized service to your patient.

Diagnosis/Condition: (Include Physical, Mental Health, Learning Disabilities and AODA

_____

_____

Prognosis: (if the patient's condition is related to pregnancy, please enter the expected date of birth)

_____

_____

In what type of treatment plan is the patient involved for the symptoms mentioned? (Include the number of hours involved in a treatment program each week and/or treatment that needs to occur during a normal workday and the type of activities or treatment, examples: physical therapy, self-initiated or organized exercise program, smoking cessation program, weight loss program, and counseling).

_____

_____

_____

This individual may have his/her vocational capacity assessed. What, if any accommodations should be provided for this assessment?_____

Does this individual have a verified physical or mental impairment which by itself or in conjunction with age, prevents the individual from engaging in employment? _____

OTHER CONDITIONS:

Are there any more restrictions that exist?_____

Please recommend activities that may improve this individual's ability to live a healthier lifestyle or become employed:

□ Work Site Activities
□ Job Readiness/Life Skills workshops
□ Job Skills Training
□ Assessment and treatment program
□ Job Search
□ Adult Basic Education Classes
□ SSI or SS(D)I Advocacy
□ Counseling or Physical Rehabilitation

Additional Recommendations, Comments or Concerns: :

_____

Name of Professional Provider	**Title**	**Telephone Number** ( )
Signature of Professional Provider		**Date Signed**

RETURN FORM TO: Oneida Economic Support Services, PO Box 365, Oneida WI 54115
Phone: (920) 490-3939 ● Fax Number: (920) 490-6803