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

General Assistance Application

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.

All applicants must provide the following information:

_____ Copy of Tribal Identification card or certificate of enrollment

_____ Copy of verification of residing on tax free land from land management office

_____ Copy of verification letter that indicates a current/pending application for Social Security disability

_____ Medical Exam Form (see attached)

NOTIFICATION TO CLIENT

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."

_____ _____

Signature Date

APPLICATION FOR GENERAL ASSISTANCE

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____
SS #: _____
ADDRESS: _____ CITY: _____ STATE: ____ ZIP _____
PHONE # _____ MESSAGE # _____

Date: _____

Problem as stated by applicant (basis for decision):

PRIVACY REDUCTION ACT AND PRIVACY ACT STATEMENT

This information is being collected to determine the degree of unmet need and arrangements for assistance. This information will be used to determine the eligibility of applicants for financial assistance or other services. Response to this request is required to obtain benefits in accordance with 25 U.C. 13.

Public reporting for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of the collection of information, including suggestions for reducing the burden, to the Information Collection Clearance Officer, Bureau of Indian Affairs, Mailstop 337-SIB, 18th & C Streets, NW, Washington DC 20240; and the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington DC 20503.

US DEPARTMENT OF INTERIOR

BUREAU OF INDIAN AFFAIRS

FAMILY PROFILE

Names of people in household including self	DOB			Sex	Social Security Number	Tribe	Relationship	Marital Status	Highest Level Education
1.							Self		
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Emergency contact:

Name_____

Relationship_____

Address _____

Phone number _____

PERSONAL AND SOCIAL HISTORY

HEALTH

Do you have any health problems (physical or mental) which require ongoing medical attention? ( ) Yes ( ) No

Do they affect your ability to do certain kinds of work? ( ) Yes ( ) No

If yes, please describe the problem(s) in your own words: _____

_____

RECORD OF INCOME AND RESOURCES

HOME

( ) Owned, value $ _____ Balance Due $_____Payments $ _____ ( ) per month ( ) per year

( ) Rented, monthly rental $_____ subsidized unsubsidized

( ) Free shelter

Type: ( ) very poor ( ) poor ( ) adequate Number of rooms_____Source of water supply _____

REAL ESTATE

Total Number of Acres: Owned _____ Assigned _____ Allotted _____ Undivided interest

Is land operated by family? ( ) yes ( ) no If yes, how many acres? _____

Estimated annual net income from farming and/or ranching: $ _____

Is all or part of land leased? ( ) yes ( ) no If yes, give number of acres leased: _____

Total annual rentals $ _____ Name of lessee _____

Name of lessee _____

VEHICLES

Type:_____ ( ) car ( ) truck

Type:_____ ( ) car ( ) truck

SOCIAL SECURITY

Information_____

Name of W/E or Beneficiary _____

SS/AN or CN _____

PENSIONS AND BENEFITS (Include public assistance and unemployment insurance, etc.

Name of recipient _____

Kind of payment_____ Amount of payment $ _____

VETERANS

Name of Veteran _____ Branch _____

Benefit Amount $ _____ Dates of Service_____VA Claim # _____

UNEARNED INCOME – OTHER SOURCES

Name of person _____

Annual amount $_____ Month available _____

US DEPARTMENT OF THE INTERIOR, BUREAU OF INDIAN AFFAIRS

EDUCATION/EMPLOYMENT INFORMATION

EDUCATION HISTORY

Circle the highest grade completed in school:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 +

Check those that describe your educational experience

( ) GED Date received (month/year) _____

( ) HS Equivalency Diploma Date received (month/year) _____

( ) High School Diploma Date received (month/year) _____

( ) Vocational Certificate Subject_____Type _____

( ) Associate's Degree Subject_____

( ) Bachelor's Degree Subject_____

If you did not complete high school, briefly state reason why: _____

If you started, but did not complete, your GED tests, please indicate those you successfully completed, and when you completed them

GED TESTS COMPLETED DATE: _____

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.

_____ _____

Signature Date

Interviewed by:_____ Date: _____

VERIFICATION OF TAX-FREE LAND STATUS

DATE: _____

TO: Oneida Land Management Office

FROM: Economic Support Attn:

RE: Verification of Residence/Land Status

The Economic Support Office /General Assistance program is requesting verification of the residence for_____, who resides at_____ since_____.

We are requesting verification of the land status as tax free land? Circle: YES NO

Comments:_____

_____

_____ _____

DOLM Staff Signature Date

MEDICAL EXAM CAPACITY FORM

Name	Date of Birth	Social Security Number

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

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 54155 Phone: (920) 490-3939 ● Fax Number: (920) 490-6803