



South Puget Intertribal Planning Agency

Workforce Development Program Cash Assistance Application for Services

Applicant Information

Your Name (First, MI, Last):	US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Name & Phone:	

Family (List everyone else living in your home even if you are not applying for them. Use extra sheets if necessary):

2	Name: (Last, First, M.I.)	Date of Birth:	Social Security #:	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to you (child, spouse, etc):	Tribal Enrollment:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Ethnicity: <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/Pacific Islander Native		
	If a child, name of school enrolled in:	Highest Grade Attended:	Need Childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for benefits for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child IEP/504: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Child's Education Goal:			
3	Name: (Last, First, M.I.)	Date of Birth:	Social Security #:	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to you (child, spouse, etc):	Tribal Enrollment:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Ethnicity: <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/Pacific Islander Native		
	If a child, name of school enrolled in:	Highest Grade Attended:	Need Childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for benefits for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child IEP/504: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Child's Education Goal:			
4	Name: (Last, First, M.I.)	Date of Birth:	Social Security #:	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to you (child, spouse, etc):	Tribal Enrollment:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Ethnicity: <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/Pacific Islander Native		
	If a child, name of school enrolled in:	Highest Grade Attended:	Need Childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for benefits for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child IEP/504: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Child's Education Goal:			
5	Name: (Last, First, M.I.)	Date of Birth:	Social Security #:	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to you (child, spouse, etc):	Tribal Enrollment:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Ethnicity: <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/Pacific Islander Native		
	If a child, name of school enrolled in:	Highest Grade Attended:	Need Childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for benefits for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child IEP/504: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Child's Education Goal:			

Household Income

I, my spouse, or someone I am applying for receives: (check all that apply)

	Who Received Income	Monthly Gross Amount
<input type="checkbox"/> Employment – Where: _____		\$ _____
<input type="checkbox"/> Unemployment Benefits		\$ _____
<input type="checkbox"/> L&I Benefits or Worker’s Compensation		\$ _____
<input type="checkbox"/> Social Security or Supplemental Security Income (SSI)		\$ _____
<input type="checkbox"/> Child Support		\$ _____
<input type="checkbox"/> Foster Care Benefits		\$ _____
<input type="checkbox"/> Retirement, Pension, Dividends, Interest or Annuities		\$ _____
<input type="checkbox"/> Dividends or Interest		\$ _____
<input type="checkbox"/> Veterans’ Benefits		\$ _____
<input type="checkbox"/> Alimony or Spousal Maintenance		\$ _____
<input type="checkbox"/> Per Capita		\$ _____
<input type="checkbox"/> Education Assistance (including grants, scholarships & FAFSA)		\$ _____
<input type="checkbox"/> Treaty Income (fishing, diving, digging, etc.)		\$ _____
<input type="checkbox"/> Other:		\$ _____

General Information

I receive or have applied for basic food assistance from a state program Yes No Amount \$ _____

I receive subsidized housing Yes No What Kind: _____

I receive subsidized Child Care Yes No Source: _____

I receive or have applied for medical assistance from a state program Yes No

I receive Child Support Yes No Amount \$ _____

I receive WIC and/or Commodities Yes No

I currently receive Cash Assistance from the state or another tribe Yes No Amount \$ _____

I am a prior Cash Assistance recipient Yes No

If yes, Where: _____ When: _____

Special Needs

Is there a pregnant woman in the household? <input type="checkbox"/> Yes, due date: _____ <input type="checkbox"/> No	If Yes, Name: _____	Teen Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone have a primary language besides English? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name: _____	Which Language? _____

Resources (Do not complete this section if you are applying for children only):

Complete this section to declare all resources (use additional sheets if necessary):

	Whose Resource?	Resource Amount/Value
Bank Account: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	\$ _____
Property (not including your home) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	\$ _____
Vehicles (boats, trailers, etc. that has a title):		
Vehicle #1: Make: _____ Model: _____ Year: _____		
Kelley Blue Book Value: \$ _____	Amount Owed: \$ _____	
Vehicle #2: Make: _____ Model: _____ Year: _____		
Kelley Blue Book Value: \$ _____	Amount Owed: \$ _____	

Declarations

Please read each of the following statements. For 2 parent households, both adults must read and sign below.

The SPIPA WFD Program Services require personal and sometimes sensitive information, confidentiality is strictly enforced. All information that is given by a cash assistance recipient will not be released, except when authorized in writing or as required by law.

I certify that all members of my household for whom I am applying for assistance are U.S. citizens or aliens in lawful immigration status.

I understand information provided on this application will be verified by federal, state and tribal officials and that information obtained through these sources could affect my eligibility and benefits.

I agree to provide the documents necessary to establish my eligibility.

I agree to fill out and turn in Monthly Eligibility Reports to continue receiving benefits.

Unless exempt, I and any persons for whom I am applying or receiving assistance agrees to meet work- related requirements. Failure to comply may result in sanctions against the household's cash assistance grant.

I agree to notify the SPIPA WFD Program office within 10 days if I have any changes in income, resources, household composition, address or living arrangements, which may affect the amount of my assistance or my right to receive assistance. If I do not report changes within 10 days after the occurrence, I understand that my case may be closed.

I authorize the SPIPA WFD Program to make any necessary investigations or requests to verify the information I have given. I authorize the release of any necessary information, documents, or forms to the SPIPA WFD Program from individual businesses, schools, public/private organizations, tribes and Washington State agencies to determine my eligibility for assistance.

I understand SPIPA WFD Program has the right to deny the application of/or prosecute anyone who knowingly provides false information and/or commits fraud to obtain assistance to which he/she is not eligible.

My (our) signature(s) below authorizes the use of my (our) Social Security Number(s) to verify benefits that I (we) receive from other State/Tribal programs (including, but not limited to, Food and Medical Benefits, current or previous TANF benefits and/or Child Support payments).

I agree to cooperate with Tribal and/or State Child Support Enforcement requirements unless good cause is granted.

The statements listed above have been explained to me and my signature below means that I understand each one.

Signatures

I (we) declare under penalty of perjury, the information I (we) provided in this application is true, correct, and complete to the best of my (our) knowledge. I (we) understand that if I (we) incorrectly receive a cash grant because I (we) have made a willfully false statement and/or I (we) have willfully failed to report information required by the SPIPA Intertribal Workforce Development Program, I (we) may be prosecuted and will be terminated from receiving benefits.

Applicant Signature	Date	Other Adult Applicant Signature, if applicable	Date
Workforce Development Program Staff Signature	Date	Signature of Witness if signed with an X	Date