OMB Control No. 1076-0017
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BIA Form # 5-6601
Revised: 6/24/22

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

AREAS ARE FOR BIA AGENCY USE ONLY.

Name: ______________________________ Tribe/Enrollment Number: ______________________

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

Mailing Address: ____

Physical Address: ______________________________ Cell/ MSG Number: ______________________

Provide directions on how to get to your home: ______________________________________

1. Reason for applying for Financial Assistance and Social Services?

2. What type of income have you been living on for the last three (3) months?

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. Place an asterisk (*) to the left of each person not included in payment.

Members of Household (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 &Signatur

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 ____________________ Amount $: ________

Household Member # 2 ____________________ Amount $: ________

Household Member # 3 ____________________ Amount $: ________

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 bo below; use additional space for further explanation.)

Earned Income		Unearned Income	
☐ Wages/ Salary	Amount: $	☐ Supplemental Security Income (SSI)	Amount: $
☐ Alimony/ Child Support	Amount: $	☐ TANF	Amount: $
☐ Gifts/ Contributions	Amount: $	☐ Food Stamps	Amount: $
☐ Income Tax Refund (Federal/State)	Amount: $	☐ Commodities	
☐ Insurance Settlement (Auto Accident, etc.)	Amount: $	☐ Foster Care Payments	Amount: $
☐ Interest/ Dividends (Bank Accounts) Other (list):	Amount: $	☐ Other (list) (Example: Carl Perkins P.L. 105-332)	Amount: $
☐ Lease Income (list)	Amount: $	☐ Other (list) (Example: Alaska Native Corporation Dividend	Amount: $
☐ Lottery/ Gaming Income (cash winnings)	Amount: $	Explain the Amount Approved and/or Disapproved- need to specify gross and net earnings. (Social Service Worker Section)	
☐ Retirement Benefits/ Pensions	Amount: $		
☐ 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 and 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: "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 not more than $10,000 or imprisoned not more than five 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 check & initial: ☐ Read, Understood & Signed the Fraud Statement: ______
☐ Read, Understood & Signed the Paperwork Reduction Act: _____
☐ Read, Understood & Signed Release of Information & Privacy Act/FOIA: _____

Date	Signature of Applicant #1	Date	Signature of Applicant #2
Date	Social Services Worker Signature	Date	BIA Line Officer (If Applicable)

Washoe Tribe Department of Social Services

Authorization to Release Information

I hereby authorize the release and full disclosure of any information concerning and relevant to my eligibility for Indian General Assistance (IGA) or other social service programs, including information of a confidential or privileged nature, to the Washoe Tribe of Nevada and California Social Services Department. I also authorize the exchange of such information by and between the Washoe Tribe Social Services Department and other relevant agencies, organizations or individuals.

I authorize the release of information, including but not limited to by way of example only, from and to: law enforcement and criminal justice agencies; attorneys; schools, colleges, training programs and other educational institutions; military organizations; hospitals, clinics, physicians, and repositories of medical records; county, state and federal government agencies; community service agencies; employers; credit bureaus and consumer reporting agencies.

The information will be used only for purposed directly relevant to the determination of my eligibility to receive services and/or benefits through the Washoe Tribe Social Services Department. I understand that such information is necessary and related to my program of services and that its confidentiality will be respected by the providers and recipients thereof. I further understand that this Authorization is valid from date signed and is subject to revocation by me at any time in writing, except to extend that action has been taken in reliance hereon.

Such information may be released to any duly authorized agent of the Washoe Tribe Social Services Department upon presentation of this Authorization in person, by mail, by fax, or by any other method of transmission. A photocopy of this Authorization shall be considered as valid as the original signed by me.

I hereby waive any physician-patient, attorney-client, spousal or other privilege I may have under the law with respect to any records made available in reliance with t his Authorization.

I hereby agree to hold harmless the Washoe Tribe of Nevada and California, the Washoe Tribe Social Services Department, all of their officers, agents, employees and related personnel, both individually and collectively, from any and all liability for damage of whatever kind which may at any time result to me, my family, heirs or associates because of reliance on and/or compliance with this Authorization.

I also release and hold harmless the custodians of any requested or shared records and information, their officers, agents, employees, and related personnel from any and all liabilities, damages and claims that might arise from the release of information authorization herein.

______________________________ Client Signature	______________________ Date:
______________________________ Social Security Number:	______________________ Date of Birth:

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