COOK INLET TRIBAL COUNCIL
People. Partnership. Potential.

Cook Inlet Tribal Council
Employment Training & Services Department
APPLICATION FOR SERVICES

Email this application to elg@citci.org

Fax this application to 907-793-3394

Questions? Call us at 907-793-3300

WHAT KIND OF HELP DO YOU NEED? *PLEASE CHECK ALL THAT APPLY*

Cook Inlet Tribal Council delivers the following services: / For State of Alaska services please check below.

☐ Tribal Temporary Assistance (TANF) ☐ BIA General Assistance ☐ Child Care

☐ Work\Support Services ☐ Education Services ☐ Youth Services

☐ COVID Assistance ☐ HPOG (Health Professional Opportunity Grant)

☐ Heating Assistance (LIHEAP) (pays a portion of home heating costs)

- ☐ I am out of fuel or have a disconnect notice for within 48 hours (attach copy of disconnect notice to this application)
- ☐ Subsidized Rental Housing Utility Deposit (SRHUD)
  helps pay a utility deposit when households are moving into Section 8 or subsidized rental housing, provided that heat is included in rent.
- ☐ Weatherization (pays a portion of home heating system modifications & repairs

State of Alaska Services:

☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Adult Public Assistance : __ blind or disabled or __ elderly assistance

☐ General Relief: __ Rent/Utilities or __ Burial

☐ Health Insurance (includes Medicaid, tax credit, private health insurance)

☐ Chronic & Acute Medical

INFORMATION ABOUT YOU:

Legal Name		Social Security Number	Other Names Used
Marital Status: Circle One	Registered for Selective Service?	Veteran?	Email Address

Regional Corporation Affiliation:
Type S= Shareholder F= Family Member D= Descendant of

____Ahtna ____Aleut ____ASRC ____BSNC
____BBNC ____Calista ____Chugach ____CIRI
____Doyon ____Koniag ____NANA ____Sealaska
____13th Regional ____None

Alaska Native Ethnicity:
____Aleut ____Alutiiq ____Athabascan
____Haida ____Inupiat ____Siberian Yup'ik
____Tsimshian ____Yup'ik/Cup'ik ____Don't Know
____Tlingit ____Eyak

Home Address or Directions to Your Home	City	State	Zip
Mailing Address	City	State	Zip

Home Phone:
Cell Phone:
Work Phone:

Emergency Contact:
Name:
Phone: Email:

Answer these questions to see if you get food stamps within seven days.

1. Is cash and money in bank $100 or less? ☐Yes ☐No
2. Is your household's monthly gross income less than $150? ☐Yes ☐No
3. Are your household's monthly rent/mortgage and utility payments more than your combined monthly gross income and liquid assets? ☐Yes ☐No

SIGN HERE:	**Date:**

NOTE: If more space is needed, please attach another piece of paper.

INFORMATION ABOUT YOU AND THE PEOPLE WHO LIVE WITH YOU *PLEASE PRINT*

Do you speak, read, and write in English with sufficient proficiency to understand and properly fill out this application? Yes ☐ No ☐ **Legal Name** **First M.I.** **Last**	**Relation to you** **If not related write NR.**	**Birth Date And Born in Alaska?**	**Sex** **M-Male** **F-Female**	**Provide the information requested below for the people for whom you want benefits.**		**Education Level**	**Ethnicity (Optional)** **Hispanic Or Latino?**	**Race (Optional)** **Select one or more:** **AN - Alaska Native** **AI - American Indian** **AS - Asian** **BL - Black/African-Am** **C - Chinese** **F - Filipino** **J - Japanese** **K – Korean** **S - Samoan** **PI - Native Hawaiian/ Pacific Islander** **V - Vietnamese** **WH - White**
				Social Security Number	**U.S. Citizen Or National ?**	**Write in highest grade completed in school, Vocational School, or College Degree**		
	Self							AN☐AI☐AS ☐ BL☐PI☐WH ☐_____
								AN☐AI☐AS ☐ BL☐PI☐WH ☐_____
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								AN☐AI☐AS ☐ BL☐PI☐WH ☐_____

Note: Disclosure of your Race and Ethnicity information is voluntary and will not affect your eligibility or level of benefits. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.

Will you claim any dependents on your tax return? ☐ Yes ☐ No

List name(s) of dependents

1. Has anyone received or is expected to receive money from a job or self-employment? ☐Yes ☐ No *If yes, complete the information below.*

Person Employed/Start Date/Schedule (ex. M-F 8-5)	Employer/Phone Number	# hours worked	hourly wage	how often paid?
		/week		
		/week		
		/week		

2. Has anyone began or expecting to begin a training program or School? ☐Yes ☐ No *If yes, complete the information below.*

Training/Educational Institution	Course of Study/Schedule (ex: Mon-Fri, 8-5 pm)	Trainer/Advisor/Phone #	Start Date	End Date

3. Has anyone received or is expected to receive any money from any other sources (not including income listed above)?

☐ None
☐ Tribal Temporary Assistance/ATAP
☐ BIA General Assistance
☐ Child Support or Alimony
☐ Veteran's Benefits
☐ Worker's Compensation
☐ Interest
☐ Alimony
☐ Pension/Retirement
☐ Education Financial Aid
☐ Social Security Income
☐ Seasonal Employment *(must complete additional form)*
☐ Foster Care Payments
☐ Cash outs of Retirement or Pension
☐ Unemployment
☐ Rental Income
☐ Support From Others
☐ Student Loans/Grants
☐ Adult Public Assistance Program
☐ Adoption Subsidy Payments
☐ Other: _____

For the checked items above, please fill out the below information (Proof must be attached to the application)

owner/source/amount	owner/source/amount	owner/source/amount

4. Do you have any of the below items?

☐ None
☐ Annuities
☐ Burial Policy Agreement
☐ Cash on Hand
☐ Certificate of Deposit
☐ Checking Account
☐ College Savings Plan
☐ Commercial Fishing Permit
☐ IRA Account
☐ Life Insurance Policy
☐ Mineral Rights
☐ Native Corporation Shares
☐ Pension Plan
☐ Retirement Funds
☐ Safe Deposit box
☐ Savings Account
☐ Stocks/Bonds
☐ Trust Funds or ABLE Account
☐ Other_____
☐ Cash App/Bitcoin/Venomo etc.

For the above checked items please fill out the below

Who Owns the Item?	**Type of Item**	**Where Held**	**Account Number**	**Total Value/Balance**

5. List any land or buildings, fishing permits, stocks, bonds, or other items of value owned by you or anyone in your household.

owner	type of property/asset	value	owner	type of property/asset	value	owner	type of property/asset	value
		$			$			$
		$			$			$

6. List all vehicles owned by you or anyone in your household (cars, trucks, motorcycles, boats, RVs, snowmobiles, etc.).

owner	type of vehicle/model	year	how is vehicle used?	value	amount owed
				$	$
				$	$
				$	$
				$	$

7. Have you moved to Anchorage in the last 3 years? ☐Yes ☐ No

8. Do you own or rent your home? ☐Own ☐Rent ☐Stay w/Relatives ☐Homeless

9. Do you pay for your home heating costs? ☐**Yes** ☐**No**

10. List how much your family pays each month for rent/mortgage and utilities.

Rent/Mortgage Amount: $

Utilities Amount: $

11. Does anyone in your household pay for child care or dependent care expenses? ☐Yes ☐No

amount $

12. Does anyone in your household pay child support? ☐Yes ☐No

If yes, who?

amount $

13. Are you requesting assistance for anyone in your household who is pregnant? ☐Yes ☐ No

If yes, who? *When is baby due?*

14. Has anyone in your household received public assistance (Temporary Assistance, cash, food stamps, Medicaid) in Alaska or any other state? *If yes, who, when and where?* ☐Yes ☐ No

15. Is any adult in your household fleeing from prosecution, custody, or confinement for a felony or class A misdemeanor? *If yes, who?* ☐Yes ☐ No

16. Have you or any member of your household been convicted of making a false statement about where they live in order to receive assistance from two or more states at the same time? ☐Yes ☐ No

17. Have you or anyone in your household been convicted of a drug-related felony for an offense that occurred on or after August 22, 1996? ☐Yes ☐No

If yes who?

17 a. Are they satisfactorily serving or successfully completed a period of probation or parole? Yes No

17 b. Are they in the process of serving or successfully completed mandatory participation in a drug or alcohol treatment program? Yes No

17 c. Have they taken action towards rehabilitation, including participation in a drug or alcohol treatment program? Yes No

17 d. Are they successfully complying with requirements of their re-entry plan? Yes No

18. Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996? ☐Yes ☐No

19. Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996? ☐Yes ☐No

20. Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? ☐Yes ☐No

21. Have you or any member of your household been convicted of aggravated sexual abuse, murder, sexual exploitation and abuse of children, or sexual assault on or after February 7, 2014? ☐Yes ☐No

21 a. Are they serving or have they successfully completed a period of probation or parole? Yes No

21 b. Are they successfully complying with the requirements of their re-entry plan? Yes No

22. Child Support Cooperation Section: TANF Applicants only fill out Questions 22-27

Child's Full Name	State Child Born In	Absent Parent's Full Name	Is there a court custody order	Are both Parents on Birth Certificate
			☐ Yes or ☐ No	☐ Yes or ☐ No
			☐ Yes or ☐ No	☐ Yes or ☐ No
			☐ Yes or ☐ No	☐ Yes or ☐ No
			☐ Yes or ☐ No	☐ Yes or ☐ No
			☐ Yes or ☐ No	☐ Yes or ☐ No

23. Non-Custodial Parent Date of birth:
24. Non-Custodial Parent occupation:

25. Does the Non-Custodial Parent have medical insurance for the children? ☐ Yes ☐ No

26. Non-Custodial Parents Place of Birth:
27. Address:

City/State/Zip

Child Support Cooperation and Assignment of Support

You are required by law to help get child support for a child receiving Temporary Assistance (ATAP/TANF) payments or medical support for a child receiving medical assistance (Medicaid). This means you must help locate a non-custodial parent or establish paternity for a child with no legal father. You must sign over to the State or Tribe any child/spousal support or medical support owed to you for any months you receive assistance. If the non-custodial parent pays support payments to you while you are receiving Temporary Assistance, you must turn the payments over to Child Support Service Division (CSSD). You must do this even if no support order is in effect.

☐ If CSSD sends a payment to you in error, they will contact you for repayment of that money. If you want to repay gradually out of future child support payments, instead of immediately in a lump sum, check this box.

Supplying Information to CSSD – Confidentiality and Safety

If you believe that cooperating with CSSD to get child or medical support will bring harm to you or your children and you can provide support for your belief, you may claim good cause for not cooperating. You will be asked by a case worker to complete "good cause" claim forms. It is up to the caseworker to decide if you have good cause for not cooperating. CSSD will continue to pursue child or medical support against the non-custodial parent, even if you DO NOT cooperate, unless Cook Inlet Tribal Council approves good cause. Please check one of the boxes and sign below.

☐ I agree to cooperate with CSSD.
☐ I agree to cooperate with CSSD but I want my address kept confidential.
☐ I believe I have good cause to not cooperate with CSSD.

Signature_____ Date_____

If you are not applying for medical assistance, skip questions 28-31.

28. **Is anyone in your household eligible for personal or employer-provided health insurance, Public Health Service, Indian Health Service, TRICARE, or VA benefits?** ☐Yes ☐ No

If yes, complete the following:

names of insured persons	insurance company name, address and phone number	policy and group number

29. **Does anyone in your household have Medicare coverage?** *If yes, complete the following:* ☐Yes ☐ No

person's name	Medicare claim number	person's name	Medicare claim number

30. **Does anyone in your household have unpaid medical bills from the last three months?** ☐Yes ☐ No

If yes, who? *What months?*

31. **Does anyone in your household have medical problems or medical costs due to an accident?** ☐Yes ☐ No

If yes, who? *Date of the accident*

If you are not applying for childcare assistance, skip questions 32-38.

32.Does anyone in your household pay Health Insurance Premiums (Medical, Vision, Dental only) ☐Yes ☐ No

33.Do your assets exceed $1,000,000? ☐Yes ☐ No

34. **Do you have a shared custody schedule?** ☐Yes ☐ No

35. **Do any of the children in your household have special needs requiring additional services while in child care?** *If yes, additional documents will be requested.* ☐Yes ☐ No

36. **Mode of Transportation** *½ hour of travel time to and from childcare is permitted.*

☐People Mover ☐Own Transportation ☐Other:_____

37. **Does anyone in your household receive Native Corporation Dividends?** ☐Yes ☐ No

*If yes, who and how often?*_____

The first $2000 per household member, per calendar year, is excluded from countable household income. Attach year-to date verification for each family member, from each corporation.

38. List all children within your household for whom you are requesting childcare assistance and have legal custody. Child care may ONLY be used while parents are in their approved activities. Providers must be Licensed or Approved through the State of Alaska and registered with this program before an authorization and payment can be issued. Please make sure your provider will accept CITC Child Care Assistance before applying for your child(ren).

Name of Child	Name of Child Care Provider	Expected Start Date
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		
☐ Needs child care ☐ Attends ASD		

Please circle providers name above if the registration fee is needed.

If you are not applying for heating assistance or weatherization, skip questions 39-45.

39. **Are you or anyone in your household:** ☐ Legally Disabled ☐ Age 60 or over ☐ Receiving Public Assistance ☐ N/A

40. **Have you or any of the adults in your household applied for Heating Assistance from the State of Alaska (SOA) Heating Assistance Program?** Yes ☐ No ☐

**if "yes," stop here. You cannot receive Heating Assistance from both the SOA and Tribal or Native organization*

41. **Are there any other individuals living with you at this residence who are not listed as part of your household on pg. 2 of this application?** ☐ Yes ☐ No

If yes, list the names of roommates or other individuals living at this residence and describe how rent and utility expenses are shared.

_____

_____

_____

42. **If your household income does not cover your basic living expenses, explain how you are paying these costs.**

Rent:_____

Utilities:_____

Food:_____

43. Questions about your residence

Please note: all questions on this page need to be completed or your application will be considered incomplete and processing will be delayed.

What type of housing do you live in? Check the below box that applies

Apartment of Condominium:
☐ Duplex 2 units
☐ Triplex 3 units
☐ 4 of more units

☐ House
☐ Studio/Efficiency
☐ Travel Trailer (less than 35 feet)
Lean-to attached ☐*Yes* ☐*No*

☐ Van or Car*
☐ Group Home

☐ Pick-Up Camper*
☐ Tent*
☐ Mobile Home (35 Feet or longer)

☐ Renting a Room
☐ Motel/Hotel/Hostel*

☐ Cabin
☐ Boarding Home*
☐ Boat

**If you live in temporary housing, provide a signed statement from someone who can prove that you have lived there for 60 consecutive days.*

A. If you live in a trailer or mobile home 35 feet or longer, what is the exterior Length:_____ ft. and Width:_____
B. How many bedrooms are in your home? (A loft counts as one bedroom)_____
C. How much rent or mortgage do you pay each month? Rent: $_____ Mortgage: $_____ Space Rent: $_____
D. Is your rent based on 30 percent of your income (Subsidized or Section 8)? ☐*Yes* ☐*No* *if you answered yes, attach a copy of your rental housing worksheet and utility allowance worksheet (obtained from your housing agency)*
E. We may need to contact your landlord or manager to get information to process your application.
Name of Landlord:_____ Address:_____ Phone:_____

44. Questions about your heating and electric

A. What is your main heat source? (Check only one. If you have more than one, check the one you use the most)

☐ Natural Gas ☐ Fuel Oil ☐ Electricity ☐ Kerosene ☐ Coal ☐ Propane ☐ Wood ☐ Other:_____

B. If you heat with wood, do you harvest it yourself? ☐Yes ☐No
C. Who pays for your home heat? ☐ Self ☐ Landlord ☐ Other *(if other please explain)* _____
D. Who pays for your electricity? ☐ Self ☐ Landlord ☐ Other *(if other please explain)* _____
E. If you pay both heat and electricity, should part of your grant be sent to your electric account? ☐Yes ☐No

- Attach copies of your most recent fuel statement, electricity bill, or wood vendor receipts
- If heat is included in your rent, attach a copy of your rental agreement and most recent rent receipt or a statement from your landlord showing heat is included in your rent.

45. Questions about your fuel and/or electric company

A.

Name of Fuel Company	Account Number	Name on Account	Amount of Current Bill

B.

Name of Electric Company	Account Number	Name on Account	Amount of Current Bill

C. If your account for fuel or electric is in someone else's name, please explain:_____
_____
_____

AUTHORIZED REPRESENTATIVE

I have asked the below listed person to help with my public assistance case.

☐ **I understand that an additional Authorized representative form will be filled out during my interview for services.**

Name of Person _____ Phone/Message Number _____

ALTERNATE

Do not complete this section if you do not want someone else to receive or spend your Tribal Temporary Assistance or Food Stamp assistance.

I want this person to be able to receive and spend my Tribal Temporary Assistance or Food Stamp benefits on behalf of my household.

Which assistance? ☐ Cash ☐ Food

Name of Person _____ Phone/Message Number _____

Address _____ City _____ State _____ Zip _____

Food Stamps Subsistence Statement--for rural areas only

Does your household live in a rural community in which access to retail stores is difficult and you intend to rely on subsistence hunting and/or fishing for substantial portion of your food? If so, you may be able to use SNAP benefits to buy subsistence hunting and fishing items such as nets, lines, hooks, fishing rods, and knives.

Do you want to use SNAP to buy subistence hunting and fishing items? ☐ Yes ☐ No

I agree not to use the items purchased for commercial purposes. ☐ Yes ☐ No

Signature of Applicant or Other Adult Household Member _____ Date _____

Read and initial next to each statement below confirming that you understand and agree:

I understand that I must be a current Alaska resident to qualify for Public Assistance benefits administered by Cook Inlet Tribal Council, Inc or the Alaska Division of Public Assistance. I further understand that, if my residency status changes, I must report the change to Cook Inlet Tribal Council, Inc and/or the Alaska Division of Public Assistance within 10 days. I further understand that if I leave the state for 30 or more days, I must notify Cook Inlet Tribal Council, Inc and/or the Alaska Division of Public Assistance of my absence, regardless of whether I consider myself an Alaska resident/intent to return to Alaska, or not.

_____
Initial Here

I understand that eligibility for Public Assistance is determined in part by how much income my household has as its disposal. To that end I understand that this application requires that I disclose all income received by myself and members of my household, including but not limited to income from the following sources. Employment (including Self-Employment), Alimony, Child Support, Unemployment, Net Rental/Royalty, Pension/Retirement Supplemental Security Income, Veteran's Benefits, and Social Security Benefits.

_____
Initial Here

I understand that eligibility for Public Assistance is determined in part by how many assets my household has at its disposal. To that end, I understand that this application requires that I disclose all assets possessed by myself and members of my household, including but not limited to the following types of assets: Property (regardless of whether the Property is paid for, still being paid for, or is jointly owned with someone else), all Bank Accounts (including checking and savings accounts), Cash on Hand, Certificates of Deposit, College Savings Plans, Life Insurance Policies, Pension Plans, Retirement Funds, Stocks Bonds and Annuities, Native Corporation Shares, Trust Funds, Safety Deposit Box contents, Mineral Rights, IRA Accounts, Commercial Fishing Permits, and Burial Policy Agreements.

_____
Initial Here

STATEMENT OF TRUTH

Under penalty of perjury or unsworn falsification, I certify and acknowledge that the statements made on the application and during my interview for assistance regarding the persons in my home, income, resources, property, and all other items that pertain to my possible eligibility for benefits are true and correct to the best of my knowledge. I have read (or had read to me) my rights and responsibilities as descripted in the “Your Rights and Responsibilities” document during the program interview.

Signature of Applicant	Date	Signature of Other Adult Applicant	Date
Signature of Other Adult Applicant	Date	Signature of Other Adult Applicant	Date
Signature of Fee Agent or Helper	Date	Signature of Witness if Signed with an “X”	Date

PARTICIPANT APPEAL (cash assistance programs only)

If you disagree with an action taken by the CITC Employment and Training Services Department which may affect your cash assistance, you may file an appeal within 30 days of the action. During the 30 days of your appeal date, you may continue to receive cash assistance *if* you request it in writing until a CITC agency appeal decision is made. If the appeal decision is not in your favor, you will be responsible to pay back any extra cash assistance you received while awaiting the appeal decision.

CITC CLIENT GRIEVANCE

If you disagree with the services offered, or the way you are treated, you must follow the client grievance procedure outlined in CITC Policy #3.100. The first step in either an appeal or grievance is to contact the staff with whom you have a complaint to attempt to resolve the disputed action. If you are unable to resolve the disputed action with the staff, you then meet with the staff's supervisor who will work with you to resolve the complaint. For a grievance, if your complaint remains unresolved, you then provide a written complaint within 30 days of event that caused the grievance to the CITC CRP Officer at 3600 San Jeronimo Drive, Anchorage, AK 99508 who will work with you until a solution has been reached.

CHANGES IN HOUSEHOLD CIRCUMSTANCES

You must report changes in your household within 10 days of when you learn of the change. You may do this by contacting the CITC ETSD office by phone, in person or in writing. Reporting changes such as income and resources or changes in your household to other agencies **does not exempt** you from reporting changes to CITC ETSD. You are required to report the following changes:

1. Changes in employment-starting or stopping a job, change in wage rate, change from part-time to full-time or full- time to part-time.
2. Changes in the source of unearned income and changes in the amount of total unearned income greater than $50.00 per month (Examples: Social Security or Unemployment).
3. When someone moves into or out of your home (If a child is/or going to be absent it must be reported **within 5 days**).
4. If you change your residence or get a new mailing address; we need to verify your new shelter costs if you move or we cannot use them in calculating your cash assistance.
5. If your household gets a vehicle, sells a vehicle or sells any other item to obtain cash.
6. If your household has more than $2000 in cash or money in bank accounts.
7. Changes in your legal obligations to pay child support.
8. Childcare- if changing providers, you must notify our office and you must comply with your provider's policies.
9. Please report any other factors you think may affect your case or eligibility for the services.

WORK/SCHOOL REQUIREMENTS

Tribal Temporary Assistance for Needy Families (TANF) and General Assistance (GA) are Work First Services. To receive services you may have to participate in work activities. TANF and GA participants must meet with their case worker and develop a self-sufficiency plan that lists steps you will take to become financially independent. You must participate in approved work activities unless you qualify for an exemption. If you are employed and voluntarily reduce your hours, income, or quit your job without good cause and do not have approval from the case worker, a job quit penalty may be applied to your case. If you are an unmarried minor parent, to receive Tribal TANF you must live with a parent or in another approved living arrangement and attend school or training. If you have school age children they must be enrolled, attending school and making progress. Failure to provide school attendance and grade verification reports may result in a penalty being applied to your case. If you do not fulfill these work and education requirements, or minor parent requirements your cash assistance may be reduced or ended. You must also report within 10 days when your child graduates from high school.

HOME VISITS

A CITC Compliance Officer may visit your home unannounced between 7:00 am to 8:00 pm to verify all information reported. Cooperation with the Compliance Officer is required. If you do not cooperate with the Compliance Officer home visit, your TANF, GA, Child Care or Heating Assistance case will close. A Case Worker and Eligibility Technician may also conduct a regular home visit. These home visits are scheduled with you or you are given 10 days' notice prior to the visit. It is in your best interest to cooperate with these home visits. If there is no cooperation, your assistance could be reduced or closed.

FRAUD PENALTY WARNINGS/OVERPAYMENTS

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or attempt to receive cash assistance, supportive services, or other services through ETSD that you may not be eligible for, or to help someone else receive ETSD services for which they are not eligible for. By accepting services, you understand and agree that you may have a responsibility of repayment of any services or cash assistance you wrongly received caused by yourself or CITC staff.

WARNING: Any information you provide to any CITC program may be used against you in a Court of Law or for implementing an Administrative Disqualification Hearing which will result in an Intentional Program Violation disqualification from the above-mentioned services.

If you misrepresent your residence or identity to receive multiple services to include cash assistance, you can be barred from receiving Tribal TANF for 10 years. Other penalties may also apply.

EMPLOYMENT & SUPPORTIVE SERVICES

If your cash assistance case closes due to earnings, you may still be eligible for other services to help your family become self-sufficient. Please contact the CITC ETSD office for more information.

CHILD SUPPORT INFORMATION AND COOPERATION

Alaska must collect child support and medical support from any parent who has the duty to pay support to a Tribal TANF recipient. This includes any money owed to you at the time you apply, as well as current and future child support payments.

Any child support payments given or paid to you while receiving Tribal TANF must be reported and turned over to the CITC Tribal TANF office immediately. If you wish to change a child support order, you must obtain a new court order or get permission from the State of Alaska Child Support Services Division (CSSD).

Note: While on TANF If you believe you have a good reason not to cooperate with CSSD, you must tell your eligibility technician or case manager immediately. You may be asked to provide information to support your reason.

When you apply for Tribal Temporary Assistance you must:

- Sign over to CITC Tribal TANF, your right to receive and keep child support payments due to you or to a child on Tribal TANF.
- Cooperate with CSSD by providing information to establish paternity, help locate an absent parent, and enforce a child support obligation.
- Non-cooperation with CSSD or failure to turn over to CITC payments received from CSSD can result in a penalty applied to the case, payee or case closure.

AMERICANS WITH DISABILITIES ACT OF 1990

Cook Inlet Tribal Council, Inc. complies with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the CITC Corporate Affairs Officer at (907) 793-3407.

SOCIAL SECURITY NUMBERS

You must provide or apply for a social security number for yourself and each household members for whom you are seeking assistance from CITC Tribal TANF (42 CFR 435.910). CITC will use social security numbers to access information from the Social Security Administration data system.

SPENDING POLICIES FOR TANF/GA SERVICES: Under Federal Law (section 4004(c) of P.L. 112-96) it is illegal to make purchases with or to access cash assistance on EBT cards/gift cards at any bars, liquor stores, marijuana stores, gambling or adult entertainment establishments. If you fail to abide to this policy a payee may be required.

I certify that I have read and understand the entirety of this document

Signature of Participant Date Signature of Other Adult Date

Cook Inlet Tribal Council, Inc.

Client Grievance Policy Acknowledgement Statement

I have read and been briefed on the CITC Client Grievance Policy and Procedures. I fully understand my rights and responsibilities as a CITC Program Recipient.

Client Signature:

Date:

Distribution: One copy to the Client and the original form for the CITC Office File.

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COOK INLET TRIBAL COUNCIL

REQUEST FOR CONTACT PERSONS AND ORGANIZATIONS

We often need to contact persons or organizations that can verify your situation to determine your program eligibility. When we contact these persons or organizations, we tell them our name, title, and that we work for Cook Inlet Tribal Council's ETSD Programs. We are prohibited by law from telling them anything about you or about your CITC Case.

The information we most often need to verify is where you live, who lives with you, and your household's income and resources and absent parent information.

Please provide the information requested below:

NAME OF SOMEONE WHO KNOWS YOU WELL _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

NAME OF SOMEONE WHO KNOWS YOU WELL _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

NAME OF LANDLORD _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

FINANCIAL INSTITUTION (BANK, CREDIT UNION) _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

EMPLOYER _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

Cook Inlet Tribal Council, Inc. / Alaska Native Justice Center / Clare Swan Early Learning Center / Get Out the Native Vote
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907) 793-3600; Fax (907) 793-3423

Authorization to Release Personal Information

Participant's Name: _____ DOB : _____ Month/DayYear Last four digits of SSN: _____

The signature below of ☐ Participant ☐ Parent ☐ Legal Guardian authorizes CITC and related entities[1] to release protected health and other information to the following:

Name: _____
(Facility, Organization, or Individual Name)

Address: _____ Phone: _____

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. Other specifications, if any:

_____

_____

Psychotherapy Notes, as defined by HIPAA, CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records. Nothing listed on this ROI is considered Psychotherapy Notes.

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION RELEASED: (circle and initial all that apply)

☐W /	☐E /	☐V ____	Admission Summary	W /	E /	V ____	Legal History
☐W /	☐E /	☐V ____	Application for Services	W /	E /	V ____	Medication Records
W /	E /	V ____	Attendance/Progress Report	W /	E /	V ____	Medication Records – Substance Use
W /	E /	V ____	Billing Information	W /	E /	V ____	Psychiatric Evaluation
☐W /	☐E /	☐V ____	Career Development Assessment	W /	E /	V ____	Psychological Evaluation
W /	E /	V ____	Discharge Status	W /	E /	V ____	Psychosocial History
W /	E /	V ____	Education Assessments	W /	E /	V ____	Service Plan (non-clinical)
W /	E /	V ____	FAS/FASD Assessments	☐W /	☐E /	☐V ____	Supportive Services
W /	E /	V ____	Health History/Physical Records	W /	E /	V ____	Treatment Plan (clinical)
☐W /	☐E /	☐V ____	Household composition	W /	E /	V ____	Treatment Recommendations for Level of Care (residential or outpatient)
☐W /	☐E /	☐V ____	Housing				
W /	E /	V ____	Immunization Records				
☐W /	☐E /	☐V ____	Income and Wages	☐W /	☐E /	☐V ____	Other(specify) _____
W /	E /	V ____	Lab Reports (OCS and PO)				

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies, information covered by the Violence Against Women Act (VAWA) and other information through Q and/or Parent Connect and other resources, between CITC (and related entities) and ASD, and within CITC and related entities. If I am seeking VAWA services, I understand I do not have to agree to share my information. CITC and related entities will still help me and provide services to the fullest extent legally permissible. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC or related entities. I understand that I may request a copy of the records being released at any time**. _____(initial)

1. I understand: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.

2. I understand: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and in writing or orally for substance use disorder treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

   Unless otherwise revoked, this authorization will expire on the following date: _____. If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.

3. I understand my alcohol and/or drug treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA) and its enacting regulations and, that depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. I understand that only health information covered by 42 C.F.R. Part 2 (*i.e.,* alcohol and drug use or treatment), will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand my records that are subject to HIPAA cannot be disclosed by CITC or related entities and their programs beyond what is permitted under this authorization without my written consent, unless provided for by regulation.

4. I understand that information covered by VAWA may be disclosed and understand the type of information, reason for sharing and potential recipients.

5. ☐ _____ **(Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**
   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

_____ _____
Signature **Date**

_____ _____ _____
Signature of Guardian/Parent/Authorized Person **Relationship to Participant** **Date**

_____
Printed Name

Signed copy received by participant: ☐ ____Yes ☐ _____No, participant declined copy.
init init

[1] Related entities include the Alaska Native Justice Center, Inc. (ANJC), Clare Swan Early Learning Center (CSELC), and Get Out the Native Vote (GOTNV).

Cook Inlet Tribal Council, Inc. / Alaska Native Justice Center / Clare Swan Early Learning Center / Get Out the Native Vote
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907)-793-3600; Fax (907)-793-3423

Authorization to Obtain Personal Information

Participant's Name: _____ DOB: _____ (Month /Day/ Year) Last four digits of SSN: _____

The signature below of ☐ Participant ☐ Parent ☐ Legal Guardian authorizes CITC and related entities[1] to obtain protected health information and personal information from the following:

Name: _____
(Facility, Organization, or Individual Name)

Address: _____ Phone: _____

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services.
Other specifications, if any: _____

Psychotherapy Notes, as defined by HIPAA, CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records Nothing listed on this ROI is considered Psychotherapy Notes.

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION OBTAINED: (circle and initial all that apply)

☐W / ☐E / ☐V ____Admission Summary			W / E / V ____Legal History		
☐W / ☐E / ☐V ____Application for Services			W / E / V ____Medication Records		
W / E / V ____Attendance/Progress Report			W / E / V ____Medication Records- Substance ,Use		
W / E / V ____Billing Information			W / E / V ____Psychiatric Evaluation		
☐W / ☐E / ☐V ____Career Development Assessment			W / E / V ____Psychological Evaluation		
W / E / V ____Discharge Status			W / E / V ____Psychosocial History		
W / E / V ____Education Assessments			W / E / V ____Service Plan (non-clinical)		
W / E / V ____FAS/FASD Assessments			☐W / ☐E / ☐V ____Supportive Services		
W / E / V ____Health History/Physical Records			W / E / V ____Treatment Plan (clinical)		
☐W / ☐E / ☐V ____Household composition			W / E / V ____Treatment Recommendations for Level of Care (residential or outpatient)		
☐W / ☐E / ☐V ____Housing					
W / E / V ____Immunization Records					
☐W / ☐E / ☐V ____Income and Wages			☐W / ☐E / ☐V ____Other(specify) _____		
W / E / V ____Lab Reports (OCS and PO)					

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies, information covered by the Violence Against Women Act (VAWA) and other information through Q and/or Parent Connect and other resources between CITC (and related entities) and ASD, and within CITC and related entities. I understand if I am seeking VAWA services, I do not have to agree to share my information. CITC and related entities will still help me and provide services to the fullest extent legally permissible. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time**. _____(initial)

1. I understand: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.

2. I understand: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and in writing or orally for substance use disorder treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

   Unless otherwise revoked, this authorization will expire on the following date: _____. If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.

3. I understand my alcohol and/or drug treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA) and its enacting regulations and, that depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. I understand that only health information covered by 42 C.F.R. Part 2 (*i.e.,* alcohol and drug use or treatment), will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand my records that are subject to HIPAA cannot be disclosed by CITC or related entities and their programs beyond what is permitted under this authorization, without my written consent unless provided for by regulation.

4. I understand that information covered by VAWA may be disclosed and understand the type of information, reason for sharing, and potential recipients.

5. ☐ _____ **(Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**
   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

_____ **Signature** _____ **Date**

_____ **Signature of Guardian/Parent/Authorized Person** _____ **Relationship to Participant** _____ **Date**

_____ **Printed Name**

Signed copy received by participant: ☐ ____ Yes (init) ☐ _____ No, participant declined copy. (init) **CITC Employee Initials:** _____

[1] Related entities include the Alaska Native Justice Center, Inc. (ANJC), Clare Swan Early Learning Center (CSELC), and Get Out the Native Vote (GOTNV).

Cook Inlet Tribal Council, Inc. / Alaska Native Justice Center / Clare Swan Early Learning Center / Get Out the Native Vote
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907)-793-3600; Fax (907)-793-3423

Authorization to Obtain or Release (Exchange) Personal Information

Participant's Name: _____ DOB: _____ (Month/Day/Year) Last four digits of SSN: _____

The signature below of ☐ Participant ☐ Parent ☐ Legal Guardian authorizes CITC and related entities[1] to obtain from or release to (exchange with) the following Facility, Organization, or Individual, the protected health and personal information of the participant named above:

Name: _____
(Facility, Organization, or Individual Name)

Address: _____ Phone: _____

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. Other specifications or special conditions, if any:

_____

_____

Psychotherapy Notes, as defined by HIPAA, CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records. Nothing listed on this ROI is considered Psychotherapy Notes.

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION OBTAINED OR RELEASED (EXCHANGED): (circle and initial all that apply)

☐ W / ☐ E / ☐ V	Admission Summary	W / E / V	Legal History
☐ W / ☐ E / ☐ V	Application for Services	W / E / V	Medication Records
W / E / V	Attendance/Progress Report	W / E / V	Medication Records – Substance Use
W / E / V	Billing Information	W / E / V	Psychiatric Evaluation
☐ W / ☐ E / ☐ V	Career Development Assessment	W / E / V	Psychological Evaluation
W / E / V	Discharge Status	W / E / V	Psychosocial History
W / E / V	Education Assessments	W / E / V	Service Plan (non-clinical)
W / E / V	FAS/FASD Assessments	☐ W / ☐ E / ☐ V	Supportive Services
W / E / V	Health History/Physical Records	W / E / V	Treatment Plan (clinical)
☐ W / ☐ E / ☐ V	Household Composition	W / E / V	Treatment Recommendations for Level of Care (residential or outpatient)
☐ W / ☐ E / ☐ V	Housing		
W / E / V	Immunization Records		
☐ W / ☐ E / ☐ V	Income and Wages	☐ W / ☐ E / ☐ V	Other(specify) _____
W / E / V	Lab Reports (OCS and PO)		

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies, information covered by the Violence Against Women Act (VAWA) and other information through Q and/or Parent Connect and other resources between CITC (and related entities) and ASD, and within CITC and related entities. I understand if I am seeking VAWA services, I do not have to agree to share my information. CITC and related entities will still help me and provide services to the fullest extent legally permissible. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time from the facility, organization or individual that released the records pursuant to this authorization.** _____(initial)

1. I understand: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my CITC and related entities health information, I can contact the CITC Privacy Officer at 907-793-3403.
2. I understand: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for CITC and related entities PHI records, and in writing or orally for CITC and related entities substance use disorder treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

   Unless otherwise revoked, this authorization will expire on the following date: . If this space is left blank, this authorization will be presumed toexpire two (2) years after the signature date below.
3. I understand my substance use disorder treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA) and its enacting regulations and, that depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. I understand that only health information covered by 42 C.F.R. Part 2 (*i.e.,* alcohol and drug use or treatment) will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is only covered by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand my records cannot be disclosed by CITC or related entities and their programs that are subject to HIPAA without my written consent, beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.
4. I understand that information covered by VAWA may be disclosed and understand the type of information, reason for sharing, and potential recipients.
5. ☐ _____ **(Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**
   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

_____ _____
Signature **Date**

_____ _____ _____
Signature of Guardian/Parent/Authorized Person **Relationship to Participant** **Date**

_____
Printed Name

Signed copy received by participant: ☐ ____ Yes ☐ _____ No, participant declined copy. **CITC Employee Initials:** _____
init init

[1] Related entities include the Alaska Native Justice Center, Inc. (ANJC), Clare Swan Early Learning Center (CSELC), and Get Out the Native Vote (GOTNV).

ANCHORAGE SCHOOL DISTRICT
CONSENT FOR RELEASE OF EDUCATION RECORDS
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF EDUCATION RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records created or maintained by a school that receives federal funds. Completion of this document authorizes the disclosure and use of education records as described below. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

STUDENT INFORMATION:

Student Name: _____ Date of Birth: _____

Social Security Number: _____ Grade: _____

School: _____

Parent/Legal Guardian Name: _____

Relationship to Student: _____

USE AND DISCLOSURE INFORMATION:

I, the undersigned, do hereby authorize _____

(*name of agency or educational institution maintaining records*)

to disclose and deliver the complete education records maintained under the above student's name including but not limited to the following:

* Grades and transcripts
* School health records
* Psychological & Educational testing
* Special education records
* Verbal Information
* Discipline

***Please list any records you do not wish to be disclosed*: _____

The education records described above shall be delivered to:

Name: _____ Organization: _____

Address: _____

City/State/Zip Code: _____ Telephone Number: _____

PURPOSE:

This information is to be disclosed and used for the purpose of:

☐ Special Education Evaluation & Planning
☐ § 504 Evaluation & Planning
☐ Provision of Special Education Services
☐ Information for School Nursing
☐ Other _____ (*please provide explanation*).

AUTHORIZATION FOR REDISCLOSURE:

Under federal law, the requestor (School District) may not redisclose the information identified above to any other party without your prior consent. If you wish to authorize the School District to redisclose the information identified above please mark the box below:

☐ I authorize the School District to redisclose the education information described above and I understand that if the information is redisclosed it may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

My authorization for the use, disclosure and/or redisclosure of the information identified above is voluntary. I understand that the information to be disclosed or redisclosed may include individually identifiable health information. I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me.

_____ Date: _____

Signature of Student's Parent or
Student's Legal Guardian

Relationship: _____