



Three Affiliated Tribes  
477 Program  
307 5<sup>th</sup> Avenue  
P.O. Box 597  
New Town, North Dakota 58763  
Phone: (701) 627-4455  
Fax: (701) 627-2520

## 477 Program Application

Services you are requesting: (Check ALL that apply to your immediate needs.)

\_\_\_\_ Employment Education \_\_\_\_ Employment Services \_\_\_\_ Child Care \_\_\_\_ Youth Services

**Applicants must provide:**

*Tribal Enrollment Card or CDIB (Certified Degree of Indian Blood)  
Selective Service Number (Male applicants only ages 18-26)*

**If applying for EMPLOYMENT EDUCATION SERVICES, please provide the following with application:**

Basic Education/GED

\_\_\_ GED Agreement

Post Secondary Education/College

\_\_\_ Acceptance Letter    \_\_\_ Class Schedule    \_\_\_ Financial Awards/Budget Letter from College

\_\_\_ Copy of Transcripts/Diploma

**If applying for EMPLOYMENT SERVICES, please provide the following with application:**

\_\_\_ Employment Letter or Employment Verification Form

**If applying for CHILD CARE ASSISTANCE, please provide the following with application:**

\_\_\_ Tribal Enrollment Card or CDIB for Child(ren) receiving assistance    \_\_\_ Provider Form for Day Care

\_\_\_ Work/Class Schedule    \_\_\_ Last Income/Wage Stub

**If applying for YOUTH SERVICES, please provide the following with application:**

**Youth School Services**

\_\_\_ School Supply receipts    \_\_\_ Athletic Shoe Receipts    \_\_\_ Youth Camps    \_\_\_ Dual Credit Program    \_\_\_ Other

**Other Youth Services**

\_\_\_ Copy of Household Income, such as Wages, TANF (Temporary Assistance for Needy Families, GA (General Assistance), Social Security, etc



**Family Income**

List all sources of income that you have received during the last 30 days. You must provide copies of pay stub(s) for the last 30 days as verification of income.

Source of Income	Amount	Comments
Applicants' Wages (Salary)		
Spouse's Wages (Salary)		
Social Security		
Veterans Benefits		
Unemployment		
TANF (Temporary Assistance for Needy Families)		
General Assistance (GA)		
Other Income		
<b>Total Income for last 30 days</b>		

**Section II Education & Training**

Highest Grade Completed: \_\_\_\_\_ Name of Public School: \_\_\_\_\_  
 Drop Out \_\_\_\_\_ Student (Pre-K to 12<sup>th</sup>) \_\_\_\_\_ GED \_\_\_\_\_ H.S. Diploma \_\_\_\_\_ Post H.S. College \_\_\_\_\_  
 Are you currently attending school/college: \_\_Yes\_\_ No Did you receive a degree: \_\_Yes\_\_ No If yes, list degree received and year graduated: \_\_\_\_\_

**Employment Education**

Name of Training Program (ie: automotive technology, business technology, computer technology, etc.)			
Name of School/College			
Mailing Address			
City	State	Zip Code	Phone Number
Length of Training Program	Start Date	Ending Date	Degree Program ___Certificate ___2-Year Associates ___Other

**Section III Employment Services**

Are you currently employed: \_\_Yes\_\_ No If yes, Full-time \_\_\_\_\_ Part-time \_\_\_\_\_  
 If working, hours per week: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

If unemployed, last date of employment: \_\_\_\_\_

Do you have a current Drivers License: \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_ Check here if you have never been employed

**Work History for the last 2 years or last 2 positions:**

Employer/Address	Telephone Number	From/To	Hour/Wage	Hours/Week

Do you receive cash assistance: \_\_\_\_ TANF \_\_\_\_ GA \_\_\_\_ SNAP \_\_\_\_ None

If you receive cash assistance, what county: \_\_\_\_\_ Date started: \_\_\_\_\_

Address of county office: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Section VI**

**Child Care Assistance**

**Please List Children Needing Child Care**

1.	4.
2.	5.
3.	6.

**CONFIDENTIALITY:** Any information I provide or that is obtained or received on my behalf is considered confidential. I understand all Employment & Training staff are required to maintain confidentiality of participants unless otherwise noted in the release of information to which I agree.

**RELEASE OF INFORMATION:** I certify the information given in this application is correct and true to the best of my knowledge and subject to verification. I hereby authorize E&T staff to obtain and release information included in the application for services sought on my behalf from other programs

By signing below, I am in agreement to abide by the policies and procedures set forth and release of information as necessary to verify my information, provided and/or obtain services on my behalf.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian (If applicant is under the age of 18 Years Old)

\_\_\_\_\_  
Date

**477 Program  
Employability Development Plan**

**Plan of Action: Services & Activities to Achieve Goals**

<b>Employment Activities</b>	<b>Education/Training</b>	<b>Other Activities</b>
___ Direct Employment	___ High School Diploma	___ Child Care Assistance
___ Work Experience	___ GED	___ School Youth Services
___ OJT (On-the-Job-Training)	___ Short Term Training	___ Other Employment Services
___ Vocational Exploration	___ 2-Year Employment Education	

**Activity Plan and Goals**

<b>GOAL #1</b>	<b>Start Date</b>	<b>Steps to Achieve Goal</b>

<b>GOAL #2</b>	<b>Start Date</b>	<b>Steps to Achieve Goal</b>

**Follow Up & Results**

<b>Termination</b>	<b>6 Month Follow Up</b>	<b>Case Managers Comments</b>
___ Entered Unsubsidized Employment	___ Contact Employer Date: ___/___/___	
___ Completed Education		
___ Other Outcome		
___ Other Non-Positive		

**Applicant Signature:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Case Manager Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Employment Training Department  
477 Program  
P.O. Box 597, New Town, North Dakota 58763

### 477 Program Authorization for Release of Information

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I hereby authorize the 477 Program of New Town, North Dakota to release or request any information that may pertain to my case and file. I understand that this is necessary because the 477 Program is a referral and funding agency. This information will remain confidential and will be used to determine if I am eligible for services.

This authorization is voluntary and remains in effect as long as I am receiving services from the 477 Program. A copy of this release will remain in my file to be used as needed.

Clients Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*\*OFFICE USE ONLY\*\*\***

The following information was requested/released:  
(Circle One)

Date: \_\_\_\_\_

Agency: \_\_\_\_\_

- Awards Letter/Budget
- Grades/Attendance & Progress Report
- EDP (Education/Employment Development Plan)
- Testing Scores
- Social Service (TANF & GA)

- Income Verification
- Verbal (Case Notes)
- Referral
- Other Agency Funding/Plan

Casemanager Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**THREE AFFILIATED TRIBES  
477 Program - Child Care Assistance  
PROVIDER REGISTRATION FORM**

PROVIDER NAME	TELEPHONE NUMBER
MAILING ADDRESS	SOCIAL SECURITY NUMBER

**TYPE OF CHILD CARE PROVIDER**

- |  |  |
|--|--|
| <input type="checkbox"/> CENTER          | <input type="checkbox"/> SELF CERTIFIED    |
| <input type="checkbox"/> GROUP           | <input type="checkbox"/> REGISTERED        |
| <input type="checkbox"/> LICENSED FAMILY | <input type="checkbox"/> APPROVED RELATIVE |

PROVIDER NO: \_\_\_\_\_ EXPIRE DATE: \_\_\_\_\_

NAME OF APPROVED CHILD:

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

By signing I certify that as a provider my home or place of business meets all applicable health and safety requirements and I have never been accused of child abuse or neglect. I understand my participation in the 477 Program may be terminated based upon failure to comply with North Dakota Department of Human Services (Licensing Division) and/or the Three Affiliated Tribes Children and Family Service program.

I understand that as a parent and/or provider participating on the 477 Program that 477 Program staff may investigate any complaints on me as a parent and/or provider.

Provider Signature	Date
Parent Signature	Date
Child Care Case Manager, Signature	Date

CHANGE OF PROVIDER FORM:

By signing I agree that this parent has a zero balance: \_\_\_\_\_  
Previous Provider Signature / Date