

ICDBG CARES Assistance Program (ICAP) Information

What is ICAP?

The ICDBG CARES Assistance Program (ICAP) is a program that assists participants that are affected by the COVID Pandemic. Funds must be used to provide assistance to prepare, prevent and respond to COVID-19. Assistance can include rent, mortgage, internet for school age children, child care, utilities, food, emergency housing, transportation and PPE.

Where can I apply?

Due to the COVID-19, we request applications and documents to be faxed to 907-793-3394 or emailed to elq@citci.org.

Applications can also be accepted at CITC at 3600 San Jeronimo Drive, Anchorage AK 99508 if you do not have access to email or fax. There is a drop box outside of the building, or it can be dropped off in person inside the building on the 1st floor.

What is the Eligibility?

Eligibility is not solely based on income. Each family is affected by COVID-19 differently so amount of assistance may vary depending on impact during the pandemic.

General Eligibility:

1. Reside within the Cook Inlet Region
2. Alaska Native/American Indian or non-native caretaker of a AK Native or American Indian child
3. Impacted by COVID-19- funds must be used to prepare, prevent or respond to the COVID-19 pandemic.
4. Below 80% of Alaska Median Income according to HH size and residence area according to HUD's income limits. Most recent limits published will be used.

You must notify us if you have already received COVID OR CARES grant from another agency or tribe.

It is not allowable to receive duplicate assistance.

What are the income limits?

80% of HUD Median income
Anchorage

Household Size	Gross Monthly Income
1	\$4,579
2	\$5,233
3	\$5,887
4	\$6,541
5	\$7,066
6	\$8,112

Matanuska Valley

Household Size	Gross Monthly Income
1	\$4,266
2	\$4,875
3	\$5,483
4	\$6,091
5	\$6,579
6	\$7,066

How long will it take?

It may take up to 30 days to process your application. You will not be required to meet with a staff person, but they may call you with questions. **Continue to pay your bills while waiting for a decision on your application.**

What if I disagree with the decision on my application?

Any person whose application is denied or not acted upon with reasonable promptness, or whose benefits are reduced or terminated, has a right to file a grievance. Grievances must be filed in writing within 30 days of the decision. Grievances may be submitted to the CITC office via email, mailed or faxed. You may request a copy of the CITC Client Grievance Policy at the CITC office or call 793-3300.



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Checklist of documents required:

- Completed Application (attached) with all household (HH) members listed, all adults must sign application. Household is considered the financial unit.
- Certificate of Indian Blood, Tribal Enrollment, or Proof of IHS Eligibility. Required for head of household or for child if non-native head of household.
- Proof of how COVID-19 impacted HH, i.e. lay-off letter, loss of income, any other documentation that can verify situation/need. Below can be used to provide this information.
- Proof of all income in the household for last 30 days from date stamp of application received by CITC. This includes all gross unearned and earned income.
- Copies of all bills/expenses that are requesting to be paid.
- Statement signed that Applicant verifies household has not received any assistance to pay for the same expense that is requested (Applicant required to sign below form)
- W-9 (required for rent assistance and some other vendors- ask CITC staff for more information)

Print Name: _____

Please provide a description of the impact of COVID-19 that is resulting in the request for assistance. Please describe the situation for the entire timeframe of assistance being requested (attach proof if able to):

List any other assistance provided to household in the form of rental, emergency housing, utilities, food, internet or any other assistance during the COVID-19 Pandemic starting in March 2020 (list who and amounts received). If you leave blank you are certifying no assistance has been received:

I certify that I am over the age of 18 and the information provided is true and accurate and by signing the form, I am under penalty of criminal prosecution if false information results in assistance for which I am not eligible.

Signature

Date



**Employment and Training Services
Department**

EMPLOYMENT STATEMENT

Caseworker: ICAP
Phone Number: 907.793.3300
Fax: 907.793.3394
Email: elg@citci.org

Proof of Income

To determine your eligibility we need proof of your income. The information we are requesting can be done by you providing your caseworker with your paystubs, payroll records, and statement from your employer. Your employer can also contact us directly.

You can use this form to provide the proof of your income we need. To use this form, you will need to complete the Employee Section, you will then need to give this form to your employer and have them complete the Employer Section. Once this form is completed, you can return this form to your local CITC office.

Employee Section

Employee's Name _____ Employee's Signature _____
 Place of Employment _____ Social Security Number _____
 With my signature, I authorize release of this information.

Employer Section

Employer's Name _____ Employer's Signature _____
 Employer's Phone # _____ Payroll's Contact # _____
 Employee's Gross Monthly Wage _____ Hourly Rate _____ Hours Per Week _____ Days Per Week _____
 Is the Job: Full Time Part Time Temporary On-Call Seasonal
 How Often Paid: Weekly Every 2 Weeks Twice A Month Monthly
 Other Compensation: Tips Room and Board Commissions Bonus
 Monthly Amount of Other Compensation _____

List the Employee's Most Recent Paychecks:

Pay Period End Date	Date Pay Received	Regular Hours	Overtime Hours	Gross Pay

If New Employment: Employment Start Date _____ First Pay Date _____
If No Longer Employed: Termination Date _____ Date of Last Paycheck _____
 Gross Amount of Final Paycheck _____
 Reason for Termination: Fired Quit Laid Off No Call/No Show Season Ended
 Please Explain _____
Health Insurance: Yes No Who Is Covered? _____ Policy # _____
 Name and Address of Insurance Company _____
 Date Coverage Began _____ Date Coverage Ends _____
 Coverage Ended Due To _____