Native Employment Works Program (NEW)

The Nooksack Indian Tribe’s NEW Program is geared to provide supportive and job retention services to enrolled Nooksack tribal members residing in Whatcom County.

Eligibility for services as follows:

1. A person entering a new permanent part-time or full-time employment  
2. Applied within, and no longer than, a six (6) month period of hire date  
3. Enrolled in Higher Education and participating in a work study program  
4. Fall within the 175% of the current HHS Poverty Guidelines  
5. Enrolled Nooksack  
6. Reside in Whatcom County

Ineligibilities:

1. Seasonal employment  
2. Temporary hire  
3. Job transfer

Some services provided include:

One time only: Employment clothing or tools  
One time only: Household hygiene products  
One time only: Food voucher  
One time only: Optical Services

For more information regarding the NEW Program, or to see if you may qualify, please call Nooksack Social services at (360) 592-0135

P.O. Box 157 • 5061 Deming Road • Deming, WA 98244  
Nooksack Social Services: (360) 592-0135 • Fax: (360) 306-5099
NEW Program Application

Please Print:

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<tr>
<th>Name: Last  First  Mi</th>
<th>Social Security Number:</th>
<th>Telephone Number:</th>
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<th>Zip Code:</th>
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<th>Mailing Address: (if different)</th>
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Do you have your GED or High School Diploma?  Yes  No
If no, are you currently working on your GED or HS Diploma?  Yes  No
Are you receiving TANF or have received TANF in 6 months?  Yes  No

Please tell us about your household:

<table>
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<tr>
<th>Name: Last, First, Mi</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Sex M/F</th>
<th>Marital Status</th>
<th>Tribal Affiliation</th>
<th>Enrollment Number</th>
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Declaration: All of the information above has been completed to the best of my knowledge. The authorized personnel have requested information from me and I understand the importance of turning in the requested documents in a timely manner. I understand that if the information is not turned in within a reasonable time my application will be closed, and any of the listed services I have applied for will have to be applied for again. Initials

I understand by signing this application that I have authorized the NEW Program to contact any person listed on this application.

Client Signature: ___________________________ Date: __________________

P.O. Box 157 • 5061 Deming Road • Deming, WA 98244
Nooksack Social Services: (360) 592-0135 • Fax: (360) 306-5099
I authorize the release of information requested by the Nooksack Tribal Social Services Agency or its agents. The requested information will only be used in the administration of the Nooksack Tribal Social Services Programs, and will not be released to any other person or agency outside of the Nooksack Tribal Social Services Program. This release of information will be in effect while I am an applicant or recipient of Nooksack Indian Tribe’s NEW Program, and for any later investigations of my eligibility and other receipt of benefits.

Persons or organizations that may be contacted include, but are not limited to: the Department of Law, the Department of Public Safety, the Department of Fish and Game, the Department of Labor, the Department of Military & Veterans Affairs, the Department of Revenue, the Bureau of Citizenship and Immigration Services, Nooksack Tribal and Bellingham Housing Authority, Social Security Administration, local governments, public assistance programs contractors and grantees, tax assessors, financial institutions, Native corporations, stock brokerage firms, landlords, employers, Social Services Departments, Elders Programs, State and Tribal Division of Child Support, State and Tribal TANF Programs, and the Nooksack Legal Department.

I further understand that I may have to sign a Consent for Release of Information with any agency to which I have been referred.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

________________________________________
Applicant Signature

________________________________________
Printed Name

________________________________________
Phone Number

________________________________________
Date

P.O. Box 157 • 5061 Deming Road • Deming, WA 98244
Nooksack Social Services: (360) 592-0135 • Fax: (360) 306-5099
# Nooksack Indian Tribe

## ENROLLMENT DEPARTMENT

### Request for Information Form

I, __________________________________________ (date of Birth): ______/____/__________, request the following information from the Enrollment Department. The request is for the following individuals:

- Myself
- Child(ren):

(Must be Parent or legal Guardian)

- Tribal Enrollment Verification
- Certificate of Indian Blood (CDIB)

Enrollment Number if known or Social Security Number of each Individual (use back of form if need more room)

Please provide this information to: ____________________________________________

And send it by: (Check one and fill out)

- Fax: Fax#: ____________________________ Attention: ____________________________

- Mail: Name: ____________________________ Address: ____________________________
  City/State/Zip: ____________________________

- Email: ____________________________ Attention: ____________________________ Email Address

Signature: ____________________________ Date: ____________________________

(Individual requesting release)

Contact Number: ____________________________ ____________________________

This form is to be filled out by the individual who is requesting information in accordance to Title 63, under 63.05.001(b)(2).

Send this form to the Tribal Enrollment Office via EMAIL enrollment@nooksack-nsn.gov or fax to (360)306-5099 ATT: Enrollment or mail to PO Box 157 Deming, WA 98244 Attention Enrollment.

Office use only:

| Date Received: ___/___/______ | Date Processed: ___/___/______ |
| Scanned and uploaded by: ____________________________ on (date): ____________________________ |
Statement of Earnings

Nooksack NEW Program

I hereby authorize my employer to provide the following information regarding my employment to the Nooksack Social Services NEW Program.

Client Name: ____________________________
Client Signature: ________________________ Date: ________________________

To Human Resources Director:

In order to provide services to the above client, we need verification of income.

Position Title: ____________________________
Start Date: ____________________________ Hours per week: _______________
Rate of pay: ____________________________ Estimated Tips: _______________
Pay periods are: □ Weekly □ Biweekly □ Monthly
Temporary employment: Yes No Regular Employment: Yes No
Company Name: ____________________________ Phone: ________________________
Company Address: _______________________________________________________
Employer Representative Name:______________________________________________
Employer Representative Title:______________________________________________
Employer Representative's signature: ________________________ Date: __________

Return completed form to: Sarah Cline | NEW Program Coordinator
PO Box 157
Deming, WA 98244
sarahc@nooksack-nsn.gov

P.O. Box 157 • 5061 Deming Road • Deming, WA 98244
Nooksack Social Services: (360) 592-0135 • Fax: (360) 306-5099