Alaska Department of Health and Social Services
Division of Public Assistance

ALASKA TEMPORARY ASSISTANCE PROGRAM
FAMILY SELF-SUFFICIENCY PLAN

Work First ☐ Families First ☐

I understand that in order to get help from the Temporary Assistance program, I must complete and follow a Family Self-Sufficiency Plan. Following this plan will help me get a job and earn income so my family no longer needs support from the Alaska Temporary Assistance Program. I will set realistic goals for my family's progress, and plan activities that will move us toward our goals. I understand that I must comply with this plan and participate in the work activities and other activities developed by me and the Division of Public Assistance or its agent.

Name: _____ Date of plan: _____
Contact Phone Number: _____ ID Number: _____
My short-term employment goal is: _____
My long-term employment goal is: _____
I intend to reach this goal and go off Temporary Assistance by: _____

☐ **The family is receiving services from other agencies: (If 'yes', complete page 3.)**

To reach my employment goal, I will take steps to achieve the following intermediate goals:

Intermediate Goals	Steps	Start Date	Review Date

Support Services needed to complete the plan (transportation, childcare, etc.):

Service	Who will arrange for it?	Who will provide it?	Who will pay for it?

Work requirement status:

___I am required to participate in work activities developed by me and DPA or its agent. Those activities are listed on this plan. My plan will be updated as my circumstances change.

____I am excused from work and work readiness activities until_____. I am still required to develop a plan and participate in family support activities that will lead to self-sufficiency for my family.

____I am partially excused from work and work readiness activities. The steps outlined on this plan were designed to meet my circumstances. I am still required to develop a plan and participate in family support activities that will lead to self-sufficiency for my family.

My next appointment with my case manager will be: _____ at _____
I agree to keep this appointment and participate in reviewing and updating my family's plan.

Additional Information:_____

Changes to this plan:

I will maintain a minimum of one monthly contact with my work services case manager.

I understand that I must contact my case manager if and when my activities on this plan need to change. _____ **(initial)**

I understand that there is a 60-month limit for receiving Temporary Assistance (including benefits from a similar program in another state) unless DPA determines that I am eligible for an extension. To date I have used _____ months of Temporary Assistance benefits.

I understand that my family may lose some or all of our Temporary Assistance benefits if I do not follow through with this plan and complete activities related to my family's self-sufficiency or my ability to work.

Release of Information: I authorize DPA or its agents to exchange information about me with work service providers, education providers, social service organizations, training agencies, work sites, employers and partners listed on this plan in order to monitor and evaluate my participation in Family Self-Sufficiency Plan activities and to assist me in achieving employment and self-sufficiency.

Participant Signature: _____Date: _____

Case Manager Signature: _____Date: _____

Alaska Department of Health and Social Services
Division of Public Assistance

Partner Agency Contact Information

Client Name: ______________________________ Date: ______________

☐ **Participated in plan development** ☐ **Collaborating** ☐ **Did not participate**

Agency Name:				
Contact Person:				
Agency Address:		City:	State:	Zip Code:
Agency Phone / Fax:	Phone:		Fax:	
Email Address:				

☐ **Participated in plan development** ☐ **Collaborating** ☐ **Did not participate**

Agency Name:				
Contact Person:				
Agency Address:		City:	State:	Zip Code:
Agency Phone / Fax:	Phone:		Fax:	
Email Address:				

☐ **Participated in plan development** ☐ **Collaborating** ☐ **Did not participate**

Agency Name:				
Contact Person:				
Agency Address:		City:	State:	Zip Code:
Agency Phone / Fax:	Phone:		Fax:	
Email Address:				

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Agency Name:				
Contact Person:				
Agency Address:		City:	State:	Zip Code:
Agency Phone / Fax:	Phone:		Fax:	
Email Address:				

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Agency Name:				
Contact Person:				
Agency Address:		City:	State:	Zip Code:
Agency Phone / Fax:	Phone:		Fax:	
Email Address:				