Alaska Department of Health
Division of Public Assistance

ALASKA TEMPORARY ASSISTANCE PROGRAM

FAMILY SELF-SUFFICIENCY PLAN

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: _____

Social Security #: ____-___-_____ ID number:_____ Case number: _____

My employment goal is: _____

I intend to reach this goal and go off Temporary Assistance by: _____

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

Intermediate Goal	Steps	Start date	Completion/ review date

Support or accommodations 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 and work readiness activities developed by me and DPA or its agent. Activities I may need to participate in include employment, job search, volunteer work experience, job sampling, on-the-job training, job readiness instruction, education, or job training.

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

☐ I am excused from work and participation in other work activities, but I will volunteer to participate in these activities.

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.

Changes to this plan:

I understand that I must contact my case manager if I want to make any changes to this plan.

Additional information: _____

I understand that for most families, 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.

I understand that my family may lose some or all of our Temporary Assistance benefits if I fail to follow through with this plan and complete work activities or other 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 welfare-to-work contractors and grantees, education providers, social service organizations, training agencies, worksites and employers I am involved with 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: _____

Participant Signature:_____Date: _____

Case manager Signature:_____Date: _____