DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

ATAP FAMILY SELF-SUFFICIENCY PLAN

Participant Name:_____ Date of plan:_____

Date of birth: _____ID number: _____ Case number: _____

I understand that the purpose of this plan is to help my family earn income and support ourselves so we no longer need support from the Alaska Temporary Assistance Program (ATAP). I expect my family to be able to reach this goal by _____. I understand that I must participate in work activities and /or other activities when assigned by the Division of Public Assistance (DPA) or its agent.

I understand that my family cannot receive more that a total of 60 months of ATAP cash assistance (including benefits from a similar program in another state) unless DPA determines that I am exempt from this time limit.

Short Term Employment Goal:	Long Term Employment Goal:

Steps Needed to Achieve Self-Sufficiency

Work Activities

- ☐ Employment: __full time __Part time
- ☐ Job Search
- ☐ Volunteer Work Experience
- ☐ Job Sampling
- ☐ On-the-Job Training
- ☐ Job Readiness
- ☐ _____

Education/Training

- ☐ High school diploma
- ☐ GED
- ☐ ESL
- ☐ Literacy improvement
- ☐ Job skills training
- ☐ Employment counseling
- ☐ _____

Other Activities

- ☐ Life Skills instruction
- ☐ Parenting skills workshop
- ☐ Establish paternity
- ☐ Help CSED locate absent parent
- ☐ Get a child support order in place
- ☐ Substance abuse assessment/treatment
- ☐ _____

Self-sufficiency activity plan

Start date	Activity/hrs per week	Who will do it?	Milestone and/or review date

Services needed to accomplish the plan

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 as assigned by DPA or its agent. Work activities to which I may be assigned include employment, job search, volunteer work experience, job sampling, on-the-job training, job readiness instruction, education, or job training.

_____Even though I am exempt from work requirements until_____, DPA or its agent may require me to do certain other activities, which will prepare me and my family to become self-sufficient.

Changes to this plan:

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

I agree to contact my caseworker no later than_____ to set a review appointment for my Family Self Sufficiency Plan. This appointment will be:

_____ in person at _____ or _____ by telephone with my caseworker.

Additional information: _____

_____

Release of Information: I authorize DPA or its agents to exchange information about me with welfare-to-work contractors and grantees, education providers, medical and 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.

I understand that my family may lose some or all of our ATAP benefits, Food Stamps, and Medicaid if I fail to complete work activities or other activities directly related to my ability to work, such as screening and treatment for substance abuse, planning for and obtaining reliable transportation, and securing stable housing.

Participant Signature: _____ Date: _____

Participant Signature: _____ Date: _____

Caseworker Signature: _____ Date: _____