NATIVE VILLAGE OF BARROW
IÑUPIAT TRADITIONAL GOVERNMENT

2026 ARPA Short Term Program
Homelessness Assistance Application

Native Village of Barrow tribal members may qualify for Homelessness assistance, under the ARPA program. To qualify, the applicant must be experiencing homelessness and unable to be placed in a shelter/home or all other primary resources are not available. Homelessness assistance is for those in need of emergency housing, have become homeless due to unforeseen circumstance, or need aid while on hold with housing placement. Native Village of Barrow has the right to deny any application that may not meet the criteria of the program.

Applicant Information

Applicant Name: _____ **Today's Date:** _____

D.O.B: _____ **Tribal Enrollment #:** _____ **SSN:** _____

Phone Number: _____ **Email Address:** _____

Previous Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Financial Hardship Declaration

Have you experienced financial hardships associated with the COVID-19 pandemic that have created or increased the risk of:

☐ Homelessness ☐ Family Violence ☐ Death in family ☐ other.

Briefly describe your situation below: *Do not release sensitive or confidential details.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you sought other housing/ shelter options:

☐ Yes, please provide the name of the facility or entity _____
_____

☐ No.

Please attach a copy of the following documents:

Letter or letters of all primary resources' denials, or rejections

Checklist

It is the responsibility of the applicant to provide all documentation listed below

- ☐ NVB ROI
- ☐ ICAS ROI
- ☐ NSB, NSB Health ROI
- ☐ Copy of government-issued I.D. or Tibal ID
- ☐ Letters or any back up document of current situation
- ☐ Denial letter or proof of rejection from primary housing /shelter or verification by Compliance Manager

Policy

Read the policy below, acknowledge and understand this is a temporary assistant, and NVB reserves the right to review and research additional sources of housing before extending aid. Misbehavior and misconduct are not valid reasons for rejection or denial of assistance from other primary sources. Aid will only be provided if the individual meets the specific eligibility criteria outlined in the policy. Furthermore, applications may be denied if homelessness is attributed to misbehavior, misconduct, or to any indication that the member's behavior is a factor for assistance eligibility in other primary sources.

Homelessness Assistance- ARPA – SLFRF category [3.11 Housing support Services for unhoused persons]

Eligibility and preferences – all NVB tribal members. No age Limit.

a) Application process – Applicant must be enrolled to NVB as a tribal member. Member must fill out an application, and ROI (s) for NVB to be able to work with other entities if needed to support the members' situation.

b) Homelessness assistance is for those in need of emergency housing, have become homeless due to unforeseen circumstance, or need aid while on hold with housing placement.

c) Typical award, and individual award limits – This program allows the member to be housed for a period of 10 days, with a possible 4-day extension for elder and disable members and ten extra days if children are involved.

d) Members are required to utilize any available supplementary aid prior to NVB providing assistance with hotel accommodations or transitional housing through this program. Refusal of utilizing the available aid may lead to NVB denying the application.

e) NVB has the right to deny assistance if other support is accessible and available to the member.

f) Limited Funding: The program has a set amount of funding available.

g) First Come, First Serve: Applications will be processed in the order they are received.

h) Program Closure: Once funding runs out, no further applications will be accepted, and the program will cease until further funding is obtained.

i) Application Approval: Applying does not guarantee approval; if funding is exhausted, applications will be denied
j) Policy may be subjected to change following this grant's federal policies.

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Acknowledgements & Attestation

I understand that providing false information, acquiring federal funding with false pretense or not notifying the Native Village of Barrow of significant changes to my application are grounds for denial of any assistance and/or civil and criminal prosecution that may be conducted by the Native Village of Barrow.

By signing below, I hereby certify and attest that all the foregoing information and attached documents are true and correct, that I have read and reviewed the program's policy. I understand that signing below allows Native Village of Barrow to verify the information provided to take part in the ARPA Short-Term Program for Homelessness

_____ _____

Applicant Signature or legal guardian **Date**

_____

Applicant Printed Name

_____

Legal guardian's name

NATIVE VILLAGE OF BARROW OFFICIAL USE ONLY

_____ _____

Receiving Staff Signature **Date**

_____

Receiving Staff Printed Name

Approved: ☐ Yes ☐ No **Denial Communicated**: ☐ Yes ☐ No

_____

ARPA Manager

_____

Compliance Manager

Reason: _____

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ARPA RELEASE OF INFORMATION

I, _____ DOB: _____ authorize Native Village of Barrow (NVB) ARPA Department to receive and exchange information with:

Name of Individual or Agency: NSB TNHA ASNA ASRC ICAS - City of Utquiavik OCS

Address: UIC State of Alaska Phone: _____

I authorize the following information to be exchanged via e-mail, fax, postal services, telephone, or in-person:

☐ **SUBSTANCE ABUSE –** treatment for any drug or alcohol abuse, lab reports, test results, diagnosis, complications, progress notes, medications, treatment plans and current status.	☐ **FINANCES –** Rate of pay, how often pay is received, number of dividends received, amount of donations received, amount of monthly assistance, number of monthly payments current or past due by client.
☐ **PUBLIC ASSISTANCE –** Date client has applied for services, date client was approved or denied services, and reason client was denied.	☐ **CHILD PROTECTION SERVICES –** Any information that pertains to any Office of Children Service (OCS), Juvenile Probation Office or Tribal Court child protection or juvenile services that has been offered in the last six months or is currently an open case
☐ **EDUCATION –** IEP Assessments and reports, testing reports, grades, attendance, and incident reports.	☐ **OTHER** _____ _____ _____
☐ **MEDICAL –** Physical, mental examinations and clinical evaluations including any information related to HIV, ARC, or AIDS if applicable. Treatment for any physical and/or mental illness. Medical records including admitting histories, discharge summaries, lab reports, test results, diagnosis, complications, progress notes, prescribe medications, treatment plan, prognosis, pre-natal care, and status update on treatment, information on any physical, mental, or emotional limitations. Psychiatric or psychological reports and IQ Scores.	

I understand that by signing this ROI, I have the right to change my mind and revoke it at any time. This must be done in writing to NVB ARPA Department. I also understand that NVB ARPA cannot be hold NVB liable for any information provided or discussed to the above entities prior to the revoke request.

_____ _____

Signature of Applicant or Guardian if minor under the age of 18 Date

_____ _____

Print Name Expiration Date

_____ _____

Address E-mail Address

_____ _____ _____

Phone Number Cell Phone Number Message Phone Number

SOCIAL SERVICES
4772 Ahkovak Street, PO Box 934,
Barrow-Utqiagvik AK 99723
Phone: (907) 852-4227

Client Consent to Release Information To ICAS

Inupiat Community of the Arctic Slope

Client Name: _____ SSN: _____-_____-_____ DOB: _____

Client Address: _____

The information is to be released from:

Name of Facility/Person/Organization: ASNA, TNHA, NSB, ASRC, NVB OCS UIC

Address: _____

City/State/Zip Code: City of Utquiavik, State of Alaska

Tel: _____ Fax: _____

Email: _____

AUTHORIZATION

I authorize the mutual exchange of information in person, by telephone, fax, or email, regarding myself between the above indicated parties for the express purpose of obtaining information that will support services, collaboration with other entities and appropriate program referrals.

Other or specific Information (Specify):

_____

_____

_____

I understand that I may cancel this authority at any time, except to the except to the extent that action has already been taken. Unless cancelled earlier by me, this authorization will expire one year from the signature date or on the specified expiration date.

Expiration Date: _____

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

NORTH SLOPE BOROUGH | Department of Health & Social Services
Emergency Case Management Shelter
P.O. Box 69 | Barrow, Alaska 99723
Phone: (907) 852-0436 | Fax: (907) 852-8150

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Patient D.O.B _____

Address _____ City/State _____ Zip _____ Phone Number _____

I, _____, hereby authorize the North Slope Borough Health Department to:
(Name of Patient/Authorized Representative)

☐ DISCLOSE information TO & OBTAIN information FROM

☐ ONLY OBTAIN information FROM (check if limiting information direction)

☐ ONLY DISCLOSE information TO (check if limiting information direction)

Organization/Name: Native Village of Barrow

Mailing Address: PO Box 1130

City, State, Zip: Barrow, Ak 99723

Phone: 907-852-4411 Fax: 907-852-8844

The purpose and need of this disclosure is (check all that apply):

☐ Further Medical Care ☐ Legal ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (specify):_____

Initial each category you want disclosed:

_____Housing

_____Income Verification

_____Medical

_____Alcohol/Drug Abuse Treatment/Referral

_____Mental Health (except Psychotherapy Notes)

Initial each category you want disclosed:

_____Entire Record

_____Only Information Related To (specify):_____

_____

_____Only Information Between The Period Of:

(date):_____and (date):_____

I understand that I may revoke this authorization, in writing, submitted at any time to the Health & Social Services Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date.

Expiration date: _____

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

I understand that the Health & Social Services Department will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

_____ _____
Signature of Patient Date

_____ _____
Signature of Authorized Representative (State Relationship to Patient) or Witness (If Signature is Thumbprint or Mark) Date