Division of Human Services
2019 version

Bureau of Indian Affairs
Social Services Assessment and Evaluation
Individual Indian Monies (IIM)

Part 1: ACCOUNT HOLDER ASSESSMENT

1.1. Identifying Information:

Name: _____ AKA's: _____
Last First MI

Sex: ☐ Male ☐ Female DOB: _____ SSN: _____ Marital Status: _____

Tribe of Enrollment: _____ Enrollment Number: _____

Mailing Address: _____

Physical Address: _____

Phone: Contact/Msg Number: _____ E-mail: _____

Purpose of Assessment:

Mother's Name:	Father's Name:
DOB:	DOB:
Tribal Enrollment:	Tribal Enrollment:
Enrollment Number:	Enrollment Number:
Address:	Physical Address:
Phone/Msg Number:	Phone/Msg Number:
Email:	Email:
Other Caretaker:	Other Caretaker:
Relationship to Account Holder:	Relationship to Account Holder:
DOB:	DOB:
Tribal Enrollment:	Tribal Enrollment:
Enrollment Number:	Enrollment Number:
Address:	Address:
Phone/Msg Number:	Phone/Msg Number:
Email:	Email:

PRIVACY ACT STATEMENT

AUTHORITY: 25 CFR Part 20 and 25 CFR Part 115. **PURPOSE:** Information collected will be used to evaluate an Individual Indian Monies account holder's circumstances, abilities, and need assistance to manage his/her financial affairs. **ROUTINE USES:** The information will be used for disbursing money by a Federal agency, which may include completing an application, assessment, and evaluation of unmet needs, which may lead to the development of a Distribution Plan. This information will be entered into Interior/BIA-8, Financial Assistance and Social Services—Case Management System, system of record. Disclosure of this information is subject to all published routine uses identified in the Privacy Act System of Records Notice interior/BIA-8, Financial Assistance and Social Services—Case Management System. Executive Order 9397 authorized the collection of your Social Security Number. **DISCLOSURE:** Voluntary; however, this information is required before the Bureau of Indian Affairs can make financial disbursements, and may result in disapproval of your Distribution Plan.

1.2. Legal Information

Is there a court order: ☐ Yes ☐ No Issuing Court: Date of Order:

Type of order: ☐ Guardianship ☐ Custody ☐ Power of Attorney ☐ Non compos mentis ☐ Other: _____

Name of Guardian/POA/Custodian: _____ Relationship: _____

Comments:	

1.3 Assessment Information:

a. Household Composition: (If account holder resides in supervised setting or relative care, address why, etc.)

Account holder resides: ☐ Independently ☐ Parental Home ☐ Supervised Setting ☐ Relative Care ☐ Other
*How verified:

Members of Household (Last, First, MI)	DOB/ Age	Gender	Relationship to Account Holder	Tribal Affiliation
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Comments:	

*Please cover the following assessment areas: Family History, Developmental/Cognitive/Education, Medical/Behavioral Health, Activities of Daily Living, Environmental Factors, Employment History, Support Networks, Other General Welfare and Client Strengths.

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1.4 Resource & Expense Information:

*Complete the table below for all resources available to the accountholder. Minor accounts must include an evaluation of resources available to parent(s)/guardian(s)/caretaker(s).

RESOURCE TABLE					
Resource	**Amount**	**Received**	**Resource**	**Amount**	**Received**
☐ Wages/Salary		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Supplemental Security Income (SSI)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Alimony/Child Support		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ TANF		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Gifts/Contributions		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Food Stamps		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Income Tax Refund (Federal & State)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Commodities		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Insurance Settlement (i.e., auto injury, fire)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Foster Care Income		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Interest/Dividends (Bank Accounts)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Social Security/Survivor/Disability Benefits		☐ Weekly ☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Lease Income		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Unemployment Benefits		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Lottery/Gaming Income (cash winnings)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Veteran Benefits/Payments		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Retirement Benefits/Pensions		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Workers Compensation Benefits		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Royalties		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Farm/Ranch Income		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Tribal Per Capita		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Medicaid/Medicare		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Home Health Care		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Other (list)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
			Total Resources Available:		**$**

Has a representative payee been appointed for any resources identified above: ☐ Yes ☐ No

Payee:		Relationship:		Phone:	

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*Complete the table below for household expenses.

HOUSEHOLD EXPENSE TABLE					
Expense	**Amount**	**Received**	**Expense**	**Amount**	**Received**
☐ Rent/Mortgage		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Child Support		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Utilities (i.e., electric, gas)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Insurance (health)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Heating (propane, fuel)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Insurance (Auto)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Groceries		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Communications		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Water-Sewer		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Auto Loan Payment(s)		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Garbage Services		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Loan		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Medical Prescription expenses		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Transportation Expense		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Household Supplies		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Other		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
☐ Personal Miscellaneous Supplies		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly	☐ Other		☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Other ☐ Monthly
			Total Expenses:		**$**

*Complete the table below for IIM Account Information:

IIM ACCOUNT TABLE					
Trust (IIM) Account	**Amount**	**Source**			
		☐ Lease ☐ Other	☐ Judgment	☐ Minerals	☐ Monthly (SSI,VA)
		☐ Lease ☐ Other	☐ Judgment	☐ Minerals	☐ Monthly (SSI,VA)
		☐ Lease ☐ Other	☐ Judgment	☐ Minerals	☐ Monthly (SSI,VA)

Comments: (Provide a summary analysis of household resources versus expenses)

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1.5 Collateral Contacts

(Expound on who contacted and date contacted)	
Representative Payee:	
Social Worker:	
Medical Provider:	
School Provider:	
Legal:	
Other:	

1.6 Summary of Findings and Recommendations:	
☐ Minor IIM Account	(Supervision Required per regulations)
☐ IIM Account is currently Supervised.	The Assessment does not require a Social Worker recommendation or Bureau Line Officer determination and is for updating purposes only as required annually for active Supervised cases.
*Provide here an assessment summary and if applicable, your recommendation to either supervise or not supervise the IIM account:	

Based on the assessment, it is: ☐ **recommended** ☐ **not recommended** To restrict and supervise IIM account as:

☐ Adult in need of financial assistance ☐ Non-compos mentis ☐ Legal Disability ☐ Emancipated Minor

Social Worker _____ Date _____

Upon review of the assessment and supporting documents, it is my determination ☐ **will** ☐ **will not** BIA;
restrict and supervise this IIM account.

Bureau Line Officer _____ Date _____

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Attachments:

- ☐ Court Orders
- ☐ Photo ID
- ☐ Financial Award Letters
- ☐ Medical Records
- ☐ Educational Records
- ☐ Guardianship Annual Report
- ☐ Behavioral Health Records
- ☐ Resource Documents (Income & Expense of Account Holder or parent)
- ☐ Other:
- ☐ Other:

☐ Assessment and Evaluation sent to applicable parties. Date Sent: _____

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PART 2: EVALUATION OF NEEDS AND DISTRIBUTION REQUEST

Account Holder:

2.1 Request: (If the request requires an itemized list i.e. clothing, travel, etc., a copy of the itemized list must be attached).

Statement of Need	Date of Request	Requested By:	Estimated Cost	Recommendation
1.				☐ Approved ☐ Partial Approval ☐ Not Approved
2.				☐ Approved ☐ Partial Approval ☐ Not Approved
3.				☐ Approved ☐ Partial Approval ☐ Not Approved
4.				☐ Approved ☐ Partial Approval ☐ Not Approved
5.				☐ Approved ☐ Partial Approval ☐ Not Approved

2.2 Justification:

Social Worker must provide justification for each decision after fully evaluating all other resources, including parental income, available to meet unmet needs. You must be specific and address how it meets the health, education, or welfare of the account holder.

Justification #1:	
Justification #2:	
Justification #3:	
Justification #4:	
Justification #5	

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Complete the table below for each item recommended for approval.

2.3 Disbursements:

	Disbursement made to	Entity Type	Disbursement related to	Receipt Required	Responsible party for receipts	Due Date
1.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		
2.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		
3.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		
4.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		
5.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		

2.4 Recommendation and Certification:

It is recommended that a distribution plan be: ☐Approved ☐Not Approved *for the payments listed in this evaluation as they are deemed in the best interest of the account holder.

Prepared by: _____

_____ _____

Signature and Title of Recommending Official Date

I approve and certify that the plan is in the best interest of the account holder.

Name of Bureau Line Officer:

_____ _____

Signature and Title of Approving Official Date

Name of Custodian/Guardian:

_____ _____

Signature Custodian/Guardian Date

Attachments:

☐ Invoice(s) of estimated costs for requested items(s)
☐ Other documentation supporting disbursement(s)

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PART 3: DISTRIBUTION PLAN MODIFICATION EVALUATION

Account Holder:
Modification:

3.1 Assessment Update

☐ Refer to the initial assessment completed by _ _____ dated:
_ _____

Please describe any specific changes since the account holder's initial assessment. Capture relevant information pertaining to changes in resources, living situations, and/or medical.

Receipts: Have all receipts been collected for the initial distribution plan?
☐ Yes ☐ No ☐ N/A ☐ Other

3.2 Request

A request is being modify the initial distribution plan developed on to include the following:

Statement of Need	Date of Request	Requested By:	Estimated Cost	Recommendation
1.				☐ Approved ☐ Partial Approval ☐ Not Approved
2.				☐ Approved ☐ Partial Approval ☐ Not Approved
3.				☐ Approved ☐ Partial Approval ☐ Not Approved

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3.3 Justification

Social Worker must provide justification for each recommendation after fully evaluating all other resources, including parental income, available to meet unmet needs. You must be specific and address how it meets the health, education, or welfare of the account holder.

Justification #1:	
Justification #2:	
Justification #3:	

3.4 Disbursements: Complete the table below for each item recommended for approval:

	Disbursement made to	Entity Type	Disbursement related to	Receipt Required	Responsible party for receipts	Due Date
1.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		
2.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		
3.		☐ Individual ☐ Custodian ☐ Legal Guardian ☐ Third Party Vendor ☐ Other	☐ Health ☐ Education ☐ Welfare	☐ Yes ☐ No		

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3.5 Recommendations and Certification:

It is recommended that a distribution plan be: ☐ **Approved** ☐ **Not Approved** *for the payments listed in this evaluation as they are deemed in the best interest of the account holder.

Date of Initial Distribution Plan: _____

Prepared by: _____

_____ _____

Signature and Title of Recommending Official Date

I approve and certify that the plan is in the best interest of the account holder.

Name of Bureau Line Officer:

_____ _____

Signature and Title of Approving Official Date

I certify that I have been consulted and agree to the terms of the evaluation and distribution plan:

Name of Custodian/Guardian:

_____ _____

Signature Custodian/Guardian Date

Attachments:

☐ Invoice(s) of estimated costs for requested items(s)

☐ Other documentation supporting disbursement(s)

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Assessment Addendum (additional narrative space):

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