IDA SAVINGS PLAN & PARTICIPANT AGREEMENT:

This Agreement, between Coconino County Health and Human Services IDA program and _____ _____ (the Participant), details a savings plan and the responsibilities of both parties in connection with the CCHHS-IDA Program.

SAVINGS PLAN:

Participant's total savings goal is $_____. Participant agrees to make deposits for a minimum of six (6) consecutive months to receive the match funds. The match funds must be completely drawn down prior to the ending date of the grant in which they are enrolled. The Participant's target monthly savings amount is $_____ (the minimum monthly savings amount is $25.00).

Do you believe you will be able to save at least the minimum amount of money consistently every month?
☐ Yes ☐ No (Explain) _____

CCHHS IDA PROGRAM RESPONSIBILITIES:

CCHHS agrees:

Match Funds – to match the Participant's IDA savings as funds are available based on the following:

For Business participants: **2 to 1**, up to **$2,000**.
For $ave2Learn participants: **3 to 1**, up to **$1,000**.

In the event the Participant does not achieve the total savings goal within the maximum time allowed by the current grant, the Participant may still receive match funds. However, to receive the match funds, Participant must have continuously saved the minimum monthly amount as agreed, must have met all other program and funder requirements, and must have enough savings and match funds to make the qualified purchase.

CCHHS IDA receives match funds from various sources. These sources require that the funds be used within a specific period of time. If for any reason match funds are unavailable, CCHHS-IDA is not liable for any loss of accrued match funds and is not obligated to provide match funds. Available match funds are provided to Participants who have completed their savings plan and all other program requirements. Upon completion of the savings plan and other program requirements, CCHHS-IDA will submit a request for match funds and determine availability of match funds.

NOTE: Participants can transfer savings and match funds to a spouse or legal dependent upon completion of the program. However, while in the program participants must use their own income. They cannot use the income of a parent or spouse.

Applicant Initials: _____

Financial Education – to provide and/or refer the Participant to financial education workshops required by match funding organizations.

Applicant Initials: _____

PARTICIPANT RESPONSIBILITIES:

The Participant agrees:
IDA Savings Account – to open an IDA savings account at a participating financial institution within thirty (30) days of enrollment.

Applicant Initials: _____

Monthly Deposits – to deposit a minimum of $25 every calendar month from his or her income (as defined by the Internal Revenue Service).

Applicant Initials: _____

Confidentiality – to respect the right to privacy of all Program Participants by keeping confidential any personal or financial information divulged during the course of the Program (for more details see Authorization for Release of Confidential Information).

Applicant Initials: _____

Notifications of Changes – to provide Program staff with updated personal information and notify Program staff regarding any changes in circumstances (e.g. employment, income or personal information changes such as phone number or address, problems with meeting savings goal, etc.) within two weeks of the change(s).

Applicant Initials: _____

MUTUAL UNDERSTANDINGS:

Both parties understand and agree that:

Program Guidelines – the CCHHS-IDA Guidelines contain a detailed explanation of eligibility criteria and other IDA Program and funder requirements.

Applicant Initials: _____

Emergency Withdrawals – Emergency withdrawals are permitted only for special circumstances and require **prior approval** from CCHHS-IDA. Withdrawals without prior approval may result in **disqualification** from the IDA Program and **forfeiture** of match funds.

Applicant Initials: _____

Account Ownership – the Participant is the sole owner of his/her/their savings account.

Applicant Initials: _____

Participation and Termination – the Participant may be **terminated** from the Program for **non-compliance** of Program Guidelines (e.g., missed monthly savings deposits, unauthorized savings withdrawals, failure to satisfactorily complete action plans, or attend the required courses, etc.). If a Participant is terminated from the program, all unused earned match funds are forfeited.

Applicant Initials: _____

CERTIFICATION:

I have read and understand the contents of this Savings Plan and Participation Agreement, and I agree to meet my responsibilities under it. Further, I certify and I have received and reviewed the Participant Guidelines, and that any questions I had about the Program have been answered to my satisfaction.

Participant's Printed Name:_____

Date_____

Participant's
Signature:_____

COCONINO IDA PROGRAM EVALUATION RELEASE FORM

I, _____understand that Coconino County Health and Human Services (CCHHS) IDA Program is participating in a program evaluation sponsored by the Assets for Arizona Institute™, other partners and/or funders. I understand that the purpose of this program evaluation is to study the effects of savings-based, asset development strategies. I agree to participate in this demonstration and in all program activities affiliated with it.

As part of my participation in the project, I agree to assist in the evaluation by sharing certain information (collected through surveys, interviews, and focus groups). I understand that all such information will be kept confidential and only released in aggregate form.

I understand that the CCHHS-IDA nor the Assets for Arizona Institute, other partners or funders, will not use my name in any report or written summary originating from information I have provided without my written consent.

I give permission to CCHHS-IDA to submit personal and financial information, including information from the financial institution holding my IDA, to the Assets for Arizona Institute™, partners or other funders for evaluation. I agree to provide all personal and financial information requested by CCHHS-IDA.

I understand that focus groups may include questions that ask about my spending patterns, my attitude toward savings and assets, and my attitude toward the IDA program itself, and I agree to provide this information. I further understand that interviews may include questions that ask about my background, how the IDA program works, my savings abilities, and the effects of the IDA program on my family, my neighborhood, and me, and I agree to provide this information.

I understand that information I provide will be used to learn about and analyze savings behavior, and that this analysis may be printed in journals and other publications for funding agencies, policymakers, and the general public.

I understand that and CCHHS-IDA and the Assets for Arizona Institute™, partners and other funders will store all data in a locked file cabinet and or secure digital files to which only authorized program staff and evaluators will have access.

I am participating in this IDA program of my own free will and I understand that I can drop out of the program at any time.

_____ _____

Participant's Name (Please Print) Date

_____

Participant's Signature

IDA DISCLAIMER AND WAIVER OF LIABILITY

Coconino County Health and Human Services Department IDA Program in collaboration with other entities provides financial and education classes and information to help individuals and families develop assets. Individual Development Accounts (IDAs) provide matching funds for families and individuals committed to a specified rate of savings over a period of time, usually at least two years. The eligible assets that can be purchased through CCHHS-$2L's IDA Program are post-secondary education tuition, fees, books, and school supplies.

Individual Development Account match funding organizations require Financial Education Training as a part of participation in the IDA Program. Personal financial and investment decisions are highly personal however, and the IDA Program's staff members do not provide individual investment advice.

Accordingly, it is very important for you to understand that you have sole responsibility for weighing all of the information you receive from the financial classes, and from the staff members to make any decisions about your savings, investments and credit. You are welcome and encouraged to seek out as much information from as many different sources as possible as you develop your savings and investment program.

Your signature below acknowledges that you have read and understand that you assume full responsibility for any decisions you make regarding your savings, investments, and credit. Further, you recognize that the CCHHS-IDA Program, partners, and MesaCAN's Assets for Arizona Institute™, have no liability to you for your own decisions and that you waive any claim for liability, contingent or actual, claim or indemnification for the investment decisions or any other financial decisions that you make while a participant in the IDA Program.

I have read and understood or have had the foregoing explained to me to my satisfaction and understand the contents of this disclaimer and waiver and hereby acknowledge that I understand the contents herein.

_____ _____

Participant's Name (Please Print) Date

_____

Participant's Signature

Authorization for Release of Confidential Information

I, THE UNDERSIGNED, understand that it may be necessary for Coconino County Health and Human Services (CCHHS) and its authorized agents to obtain information from other agencies and entities in order to make me eligible for the enrollment into the IDA Program.

Accordingly, I authorize CCHHS or its authorized agency to request information of oral or written reports, opinions, findings, documents deemed necessary for income qualifying or needed for enrollment in the IDA Program. Should said documents be deemed necessary for enrollment, I agree to provide to CCHHS upon request.

I, THE UNDERSIGNED, also understand that it may be necessary for CCHHS or its authorized agents to release information obtained from me or authorized sources to other assistance programs in order to obtain assistance through CCHHS and the various assistance programs which it administers.

In addition, I authorize CCHHS to release information to the Corporation for Enterprise Development (CFED), the Department of Health and Human Services' evaluation team or other local or national entity conducting research on IDAs.

Though I hereby waive any privilege I have to this information to CCHHS, you are further requested to disclose no information to any other person without written authority from me (pursuant to privilege and confidential communication statutes).

A photocopy, fax copy, or electronic copy of this authorization shall serve in its stead.

_____ _____

Participant's Name (Please Print) Date

_____

Participant's Signature

IDA PROGRAM - PHOTO RELEASE

I hereby grant Coconino County Health and Human Services, their successors and assigns, and those acting under their permission or upon their authority or those by whom they are commissioned:

(1) The unqualified right and permission to reproduce, publish, circulate, or otherwise use photographs, videos and/or motion pictures of me, and voice reproductions, to the extent as stated above, whether taken in a studio or elsewhere, in black and white or in color, alone or in conjunction with other persons or characters, real or imaginary, in any part of the world. This authorization expressly covers only the medium directly connected with the employment as stated above and does not include any other usage nor specifically mentioned. I hereby waive the opportunity or right to inspect or approve the finished photography, films, or tape or the use to which it may be put or the copy of illustration used in connection therewith.

(2) Additionally, I wave all my rights, title, and interest in and to all negatives, prints, tapes, and reproductions thereof, and I do hereby release the foresaid parties and their successors and assigns, in any and all rights, claims, demands, actions, or suites from which I may or can have against them on account of the use or publication of said photographs and/or motion pictures, videos, or tapes.

I have read and understand the release stated above and do hereby agree to its terms and conditions.

_____ _____

Participant's Name (Please Print) Date

_____

Participant's Signature

COCONINO COUNTY ARIZONA
Health & Human Services

Helping People. Changing Lives.
community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

CITIZEN VERIFICATION FORM

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:		
CITY, ST, ZIP:		

Arizona revised statutes §§ 1-501 and 1-502 require that anyone receiving federal, state, or local public benefits must provide one of the following documents to demonstrate lawful presence in the United States and a sworn affidavit, made under penalty of perjury, stating the document(s) presented are true. To become or remain eligible for the benefit or service you are seeking, you must complete this form and present it with one of the required documents listed below.

Failure to complete and submit this form and/or the falsification of any document or information provided herein shall subject applicant to denial, cancellation, or revocation of the requested service or benefit, and the county will be required to report any discovered violations to federal immigration law to the appropriate law enforcement agency.

Please provide one (1) of the following forms of identification (mark an "X" next to the one you will be submitting):

	An Arizona driver's license issued after 1996 or an Arizona non-operating identification license.
	A birth certificate or delayed birth certificate issued in any state, territory or possession of the United States.
	A United States certificate of birth abroad.
	A United States passport.
	A foreign passport with a United States Visa.
	An I-94 form with a photograph.
	A United States citizenship and immigration services employment authorization document or refugee travel document.
	A United States certificate of naturalization.
	A United States certificate of citizenship.
	A tribal certificate of Indian blood.
	A tribal or Bureau of Indian Affairs affidavit of birth.

By my signature below, I hereby certify, under penalty of perjury, that the document I am providing is true and that I am legally authorized to be present in the United States.

_____ _____

Signature of Applicant *Date*

For County Use Only:

Reviewed by: _____ Date: _____

COCONINO COUNTY ARIZONA
Health & Human Services

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AMERICA'S POVERTY FIGHTING NETWORK

PARTICIPANT BENEFICIARY DESIGNATION FORM

Participant Information

Name: _____ SSN: ____-___-_____

Street: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Financial institution holding IDA: _____

Beneficiary Information

*(This information MUST match what is on file with the financial institution)

Name: _____ SSN: ____-___-_____

Street: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Phone#: (_____)_____-_____ Relationship to participant: _____

Applicant Certification

In the event of my death, I designate the person listed above as my beneficiary to receive all the assets in my Individual Development Account (IDA) and I authorize Coconino County Health and Human Services (CCHHS) and the financial Institution holding my IDA to initiate and complete a transfer of my IDA assets to the control of my beneficiary.

This beneficiary designation shall remain in effect unless and until such time as I provide written and signed notification to CCHHS of a change in my beneficiary designation.

Signature: _____ Date:_____

Witness Signature: _____ Date:_____