Application

(for Workforce Investment Services)

SkillSource is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities.

Name: _____ **CMS #** _____

Today's date:	**Social security number:**
First name: **Middle Initial**:	**Last name:**
Home phone: **Message phone:**	**Email address:**
Mailing Address: **City:** **Zip Code:**	**If different, street address :** **City:** **Zip code:**
Date of birth: **Age:**	**Gender:** ☐ Male ☐ Female ☐ Decline to Identify
Are you legally entitled to work in the U.S.? ☐ Yes ☐ No Do you have a Permanent Resident Card? ☐ Yes ☐ No Do you have an Alien Registration Card? ☐ Yes ☐ No - Alien Registration Expiration Date _____	**Do you have a disability?** ☐ Yes ☐ No If yes, has it caused difficulty finding or keeping employment? ☐ Yes ☐ No
Are you currently attending any of the following: ☐ Alternative high school ☐ High school ☐ Community college ☐ Open Doors program ☐ Home School ☐ Other School ☐ None of the above	**Education level?** ☐ Some High School (highest grade completed: ____) ☐ High School Diploma ☐ GED ☐ AA Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate
Are you registered with Selective Service? ☐ Yes ☐ No ☐ Not applicable (because of age or gender)	**Military service?** (If Yes please enter dates) ☐ Yes Date entered _____ ☐ No Date discharged _____
Are you currently employed? ☐ Yes ☐ No Hourly wage $ _____ Hours per week _____ Employer: _____	**Are you receiving unemployment insurance?** ☐ Yes ☐ No

Did you lose your last job because of any of the following reasons?

☐ Terminated ☐ Laid Off ☐ Plant/Business Closure ☐ Other reason (please explain): _____

If yes, name of employer: _____ **City/State** _____

Job title: _____ **Employment End Date:** _____

Ending wage: $_____ ☐ Hourly ☐ Weekly ☐ Monthly

Are you a migrant or farmworker? ☐ Yes ☐ No

If yes: ☐ Farmworker ☐ Migrant ☐ Migrant farmworker

Type: ☐ Food Processing ☐ Agricultural Production & Services

Do you understand English?
☐ Yes ☐ No
If no, do you need an interpreter?
☐ Yes What language?_____
☐ No

Are you currently receiving a Pell Grant?

☐ Yes
☐ No

What are you studying? _____

Educational Institution? _____

Are you currently receiving public assistance?
☐ Yes ☐ No

If yes, what type?

☐ TANF $_____
- w/in 2 years of exhausting TANF? ☐ Yes ☐ No

☐ General Assistance $_____

☐ Food Stamps $_____

☐ Other: _____ $_____

Are you homeless? ☐ Yes ☐ No
Live in a temporary shelter? ☐ Yes ☐ No
Temporarily staying with friends? ☐ Yes ☐ No

Valid driver's license?
☐ Yes State? _____
☐ No

Have you been convicted or pled no contest to any criminal offense? ☐ Yes ☐ No

If yes: Date: _____ Are you currently on: Probation or parole? ☐ Yes ☐ No
Home detention ☐ Yes ☐ No
Work Release ☐ Yes ☐ No
Juvenile probation ☐ Yes ☐ No

Are you a single parent?
☐ Yes
☐ No

If you are 24 or younger,
Are you pregnant or do you have a child?
☐ Yes ☐ No ☐ N/A

Are you in foster care?
☐ Yes ☐ No ☐ N/A

Back Up Contacts:

1. Name	Relationship	Phone #
2. Name	Relationship	Phone #

For Staff Use Only

Annualized Applicant Income: $ _____ **Family Size_____ Annualized Family Income $_____**		**CASAS Reading Score:**	**CASAS Math Score:**
Low Income: ☐ Yes ☐ No	**Youth 5% Window?** ☐ Yes ☐ No	**Youth Only:** **Needs Additional Assistance?** ☐ Yes ☐ No	
Income Documented by: ☐ Family Income Sheet ☐ Self-Attestation			

Name: _____

Enter your WORK HISTORY: all jobs in the last six months and a least your last three jobs (Most recent employer first)

Employer name:	Start date:	End date**:**
Job title:	Ending salary:	Hours per week:
Reason for leaving:		
Employer name:	Start date:	End date**:**
Job title:	Ending salary:	Hours per week:
Reason for leaving:		
Employer name:	Start date:	End date**:**
Job title:	Ending salary:	Hours per week:
Reason for leaving:		

Please describe your EDUCATION and any CERTIFICATES you have earned:

School or College:	
Degree:	Completion Date:
School or College:	
Degree:	Completion Date:
Certificate:	Completion Date:
Certificate:	Completion Date:

Please list everyone living in your household:

Relationship	Last Name	First Name	Age	Dependent? (Y/N)

I certify the information provided on this document is true and accurate to the best of my knowledge and belief. I understand that such information on this application is subject to verification and further understand that the above information, if misrepresented or incomplete, may be grounds for immediate termination from any WIOA program and/or penalties as specified by law. I understand services are subject to availability of federal funds. I have been advised of equal opportunity, appeal rights, complaint procedures, and the use of my personal information.

Signature:	**Date:**

SkillSource Data Sharing Notice

The information you provide us is private and confidential and will be shared among SkillSource partners to facilitate the delivery of services to you. Examples of SkillSource partners are community colleges, community service organizations, the Department of Social and Health Services (DSHS), and the Division of Vocational Rehabilitation within DSHS, and WorkSource. The information will be shared with SkillSource partners only for the purpose of providing you employment and training-related services.

The information we will share includes personal information you provide such as your name, address and Social Security Number, other relevant identifying information, and your employment and educational history. Sharing of the information among SkillSource partners allows you to receive services from them without having to give the same information to each of the partners.

By contract, SkillSource partners are prohibited from further disclosing this information. This information is not subject to disclosure under the Public Records Act (RCW 42.17.310).

You may ask us to not share your information and we will honor that request, and your eligibility for services will not be affected. However, in order to take advantage of the services SkillSource partners offer, you will need to give each of them information about yourself. Unless you ask us to not share your information, the relevant information will be shared with our SkillSource partners, so they can assist you in employment and training-related services.

Please be advised that even if you ask us to not share your information with SkillSource partners, your information may be shared or disclosed as otherwise required by state or federal law. (AG version, 8/1/00)

I authorize sharing my data with SkillSource partners.

Signature Date

Parent authorization (if applicant is under 18 years of age):

Signature Date

SkillSource
TRAINING TODAY'S WORKFORCE IMPROVES TOMORROW'S PROFITS

Income & Family Size Worksheet

Name _____ **Date** _____ **Family Size:** _____

Please list all income received by family members in the last six months.

From _____ **to** _____

(Bring verification documents for public assistance, food stamps and any of the includable income except wages)

FAMILY MEMBER	NAME (SELF):	NAME:	NAME:	NAME:
INCLUDABLE				
Wages (before deductions)				
Self-Employment (net)				
Alimony/Maintenance				
Military Allotment				
Pension				
Income from rents/annuities				
Interest, dividends, lottery winnings				
Veteran Benefits				
Disability/Health Payments				
Scholarships/Grants (Except PELL grants)				
Unemployment (UI)				
Child Support				
Old Age & Survivors Insurance (OASI)				
Social Security Disability (SSDI)				
TOTAL LAST 6 MONTHS				
EXCLUDABLE				
Public Assistance				
Food Stamps				
Payments from training program				
PELL Grants				
Terminal leave pay				
Supplemental Security Income (SSI)				
Military Allowance				
Other				
TOTAL LAST 6 MONTHS				

I attest that the information stated above is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and further understand that the above information, if misrepresented, or incomplete, may be grounds for immediate termination from any WIOA program and/or penalties as specified by law.

Applicant Signature _____ **Date** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize SkillSource to release appropriate personal information to partner agencies only as necessary to document program eligibility, training progress and/or completion, or to support Title I activities. I understand that SkillSource will keep my personal information confidential and will not release it to unauthorized outside entities.

_____

Name (Please Print)

_____

Signature

_____

Date

_____

Social Security Number

_____

Place and Date of Birth

WIOA Summary of Rights and Procedures

RIGHTS

You have the right to file a complaint if you feel you have a complaint relating to your employment or training and will not be penalized for filing a complaint. Your complaint must contain sufficient information for us to determine who is authorized to handle the complaint.

FILING A COMPLAINT

To file a complaint, contact a local staff person and tell them that you want to file a complaint. Local staff will provide you with the necessary information and assistance to put your complaint in writing. Within 25 days of filing the complaint, a solution will be offered to resolve the matter. If you feel that your complaint is not resolved during this initial resolution effort, a hearing will be scheduled.

INFORMATION REGARDING HEARINGS

A hearing will be provided within 60 days of the receipt of a complaint, unless the complaint is resolved prior to the hearing date. The following information will be provided to you prior to the hearing date:

- The date of the notice, name of the complainant, and the name of the party against whom the complaint is filed.
- The date, time, and place of the hearing.
- A statement of the alleged violations.
- The name, address, and telephone number of the contact person issuing the notice.

DECISION AND APPEAL PROCESS

A hearing decision will be provided within 60 days of filing your complaint, unless the complaint is resolved without a hearing. If you are not satisfied with the final decision, or if a decision has not been reached within the 60-day timeframe, you may send a written and signed notice of appeal via e-mail or mail to:

ESDGPStateComplaintOfficer@esd.wa.gov
or

Attention: Complaint Officer
Employment Security Department
PO Box 9046
Olympia, WA 98507-9046

The Local Workforce Development Board is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Washington Relay Service 711.

_____ _____

Applicant Signature Date

EQUAL OPPORTUNITY NOTICE

Equal Opportunity Is the Law

It is against the law for this recipient of Federal financial assistance to discriminate on the following bases:

Against any individual in the United States, on the basis of race, color, religion, sex (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity), national origin (including limited English proficiency), age, disability, or political affiliation or belief, or, against any beneficiary of, applicant to, or participant in programs financially assisted under Title I of the Workforce Innovation and Opportunity Act, on the basis of the individual's citizenship status or participation in any WIOA Title I-financially assisted program or activity.

The recipient must not discriminate in any of the following areas:

Deciding who will be admitted, or have access, to any WIOA Title I-financially assisted program or activity; providing opportunities in, or treating any person with regard to, such a program or activity; or making employment decisions in the administration of, or in connection with, such a program or activity.

Recipients of federal financial assistance must take reasonable steps to ensure that communications with individuals with disabilities are as effective as communications with others. This means that, upon request and at no cost to the individual, recipients are required to provide appropriate auxiliary aids and services to qualified individuals with disabilities.

What To Do If You Believe You Have Experienced Discrimination

If you think that you have been subjected to discrimination under a WIOA Title I-financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either: The recipient's Equal Opportunity Officer (or the person whom the recipient has designated for this purpose); or The Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW., Room N-4123, Washington, DC 20210 or electronically as directed on the CRC Web site at *www.dol.gov/crc*.

If you file your complaint with the recipient, you must wait either until the recipient issues a written Notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (see address above). If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you may file a complaint with CRC before receiving that Notice. However, you must file your CRC complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient). If the recipient does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

Local Equal Opportunity Officer
Christy Mataya
SkillSource
240 N Mission
Wenatchee, WA 98801
christym@skillsource.org
509-293-4777/WA Relay 711

OR

The Director, Civil Rights Center (CRC)
US Department of Labor
200 Constitution Ave NW, Room N-4123
Washington, DC 20210

Or electronically as directed
on the CRC Web site at www.dol.gov/crc

I certify that I have been provided a copy of this statement:

_____ _____

Applicant Signature Date