

WORKFORCE INNOVATION AND OPPORTUNITY ACT APPLICATION

(This application will NOT be used for hiring purposes)



PLEASE PRINT CLEARLY

Last Name:
First Name:
Soc Sec #:

Date of Birth:
Age:
Gender: Female Male Decline to State

Street Address:
City/State/Zip:
Home Phone:
Cell Phone:

Mailing Address:
City/State/Zip:
Message Phone:
Email:

General Information

Are you a: Citizen of the U.S. or U.S. Territory
 U.S. Permanent Resident (*Alien/USCIS #:* _____)
 Alien/Refugee Lawfully Admitted to the U.S. (*Alien/USCIS #:* _____)
 None of the Above

Are you registered with Selective Service? Yes No

Ethnicity (you may choose more than one):

African American/Black American Indian/Alaskan Native Asian
 Hawaiian/Other Pacific Islander Hispanic White
 Other _____ I do not wish to answer

Transitioning Service Member/Veteran Information

Are you a Transitioning Service Member? Yes No
If Yes, are you: Within 24 months of retirement Within 12 months of discharge
If Yes, what is your projected discharge date: _____

Are you the spouse of a member of the armed forces who is on active duty? Yes No

Are you a veteran? Yes No
If Yes, did you serve: Less than 180 days More than 180 days
If Yes, did you serve more than one (1) tour of duty? Yes No
Date first military service began: _____
Date first military service ended: _____

Are you a Homeless Veteran? Yes No
If Yes, are you enrolled in a Homeless Veteran's Reintegration program? Yes No

Employment Information

Are you: Employed
 Employed, but I have received a notice of termination or military separation
 Unemployed

If you are currently unemployed or employed but have received a notice of termination, was it due to a closure of the business or an entire department closure within the business? Yes No

Were you self-employed and recently closed your business due to general economic conditions? Yes No

Are you participating in a Registered Apprenticeship program? Yes No

Are you eligible for or receiving Unemployment Insurance (UI) benefits? Yes No

If Yes, have you been exempted from work search requirements by EDD? Yes No

If No, have you exhausted your Unemployment Insurance (UI) benefits? Yes No

Looking back from today, have you worked at all for pay in the previous 27 weeks? Yes No

What has been your **usual** (longest continuous) occupation over the past five years? _____

Current or Most Recent Job:

Company Name:		Start Date:	/ /
Street Address:		End Date:	/ /
City/State/Zip:		Hourly Wage:	
Contact:		Weekly Hours:	
Telephone #:		Job Title:	

Reason for leaving: _____

(Office Use Only: Job listed above is a STOP GAP JOB Job listed above is the JOB OF DISLOCATION)

Education

What is the highest grade you have completed? _____

Do you have a high school diploma, GED or equivalent? Yes No

If No, and you are under 18, what is the last date you attended secondary school? _____

Do you have a post-secondary degree or certificate? Yes No

If Yes, describe degree/certificate _____

Are you currently attending school or training? Yes No

If Yes, where? _____

Services

Are you currently receiving services from any of the following?

Adult Education (WIOA Title II)? Yes No

YouthBuild? Yes No

Jobs Corps? Yes No

Carl Perkins Program (Voc Ed)? Yes No

TANF? Yes No

If Yes, are you the: Applicant Family Member

General Assistance (GA)? Yes No

If Yes, are you the: Applicant Family Member

SNAP (Supplemental Assistance Nutrition Program)? Yes No

Refugee Cash Assistance Program (RCA)? Yes No

If Yes, are you the: Applicant Family Member

Are you receiving any services under the SNAP Employment and Training Program? Yes No

Are you receiving or have been notified you will be receiving, a Pell Grant? Yes No

If Yes, enter the award amount for the school year, if known: _____

Are you receiving services in the National Farmworker Jobs Program? Yes No

Additional Information Related to Eligibility for the WIOA Program

Is English your native language? Yes No

What is your preferred language? _____

Are you Homeless? Yes No

Are you currently in the foster care system? Yes No

Have you aged out of the foster care system? Yes No

Do you have a felony or misdemeanor arrest or conviction? Yes No

(You will not automatically be denied services because you answered "Yes" to this question.)

Are you under 25 years of age and providing care for one or more children? Yes No

Have you recently lost your sole source of financial support due to a divorce, separation or widowhood? Yes No

If you receive TANF, are you within 2 years of exhausting your TANF lifetime eligibility? Yes No

Are you a single parent? Yes No

Household Size and Income Information

What is the total number of family members living in your residence (anyone, including yourself, living at home and related by blood, marriage, or decree of court)? _____

Number of dependent children in family under 18: _____

Total Estimated Family Income for the previous six (6) months: \$ _____

Certifications and Signatures

[Initial] _____ I certify that I have received a copy of the **Equal Opportunity is the Law** and **Program Grievance and Complaint Resolution Procedures** statements. I understand my rights and the process for filing an Equal Opportunity or Program Grievance complaint.

[Initial] _____ I understand that for employment and/or training purposes, information provided by me on this application, and throughout my program participation, may be shared with appropriate organizations on an as-needed basis, and as allowed by law, including but not limited to, the Employment Development Department, the Department of Social Services, the Department of Rehabilitation, and other public and private entities, including potential employers. I understand my information will be kept strictly confidential by these entities. To better serve my needs, I approve the release of this information.

My signature indicates that I have been informed of and understand the information contained on this application. I certify under penalty of perjury that all of the above information is true and complete to the best of my knowledge. I understand and agree that any information I have supplied is subject to verification. I understand that falsification of any item is grounds

Equal Opportunity Program

Auxiliary aids and services are available upon request to individuals with disabilities

for the termination of services under the Workforce Innovation and Opportunity Act program and may result in action to recover any monies paid to me while participating.

Printed Name: _____ Signature: _____

Signature of Parent or Guardian if applicant is under 18 years of age: _____

Date: _____

Office Use Only:	
Interviewer: _____	Initials: _____ Date: _____
Reviewer: _____	Initials: _____ Date: _____
Right to Work: _____ / _____	Age Verification: _____
Selective Service Status: <input type="checkbox"/> Registered <input type="checkbox"/> Not Registered <input type="checkbox"/> Exempt <input type="checkbox"/> Not Required	
WIOA Program Eligibility: <input type="checkbox"/> Adult <input type="checkbox"/> Adult, Low Income <input type="checkbox"/> Dislocated Worker	
<input type="checkbox"/> Youth (IS) <input type="checkbox"/> Youth (OS) <input type="checkbox"/> Youth (5% Window)	
<input type="checkbox"/> Special Project _____ <input type="checkbox"/> Special Project _____	
WIOA Application #: _____	EO/Program Grievance Forms in file/Staff Initial: _____
<input type="checkbox"/> Entered in CalJOBS	

Information Related to Medical/Disability Status

Applicant Name: _____

We are required by law to collect and maintain medical and disability status information separately from our routine data collection process. We collect the following information to ensure we explore all possible sources of funding to meet your employment and training needs.

Are you pregnant? Yes No

Do you have a disability? Yes No

If Yes, briefly describe your employment-related limitations: _____

Have you received services from the Veteran's Vocational Rehabilitation and Employment program, often referred to as the Chapter 31 program? Yes No

Are you currently receiving SSI (Supplemental Security Income)? Yes No

If Yes, are you the: Applicant Family Member

Are you currently receiving/have received in the last six months SSDI (Social Security Disability Insurance)? Yes No

Are you currently a Ticket-to-Work holder issued by the Social Security Administration? Yes No

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Date: _____