APPLICANT STATEMENT

APPLICANT NAME: _____ LAST 4 OF SOCIAL SECURITY #: _____

***INCOME** ☐ ***Low income has already been established. Income is not required.**

During the last six (6) months from _____ to _____, I have earned/received

$ _____
(Applicant's Income)

During the last six (6) months, my spouse, _____, has earned/received
(Spouse's Name)

$ _____
(Spouse's Income)

During the last six (6) months, another family member, _____, has earned/received
(Other Family Member's Name)

$ _____
(Other Family Member's Income)

During the last six (6) months, I or my family has *received* the following types of income:

☐ Wages
☐ Alimony
☐ CalFresh/SNAP
☐ Child Support
☐ Pension / Retirement Benefits
☐ Social Security (Old Age / Survivors)
☐ Unemployment Insurance Benefits
☐ Insurance Payments
☐ TANF
☐ Veteran's Payments
☐ Other: _____

WORK STATUS

☐ Still Employed: Hours worked weekly _____ Hourly wage $ _____
☐ Terminated/Laid Off
☐ Business/Plant Closure
☐ Previously Self Employed
☐ Voluntary Quit
☐ Displaced Homemaker
☐ Substantial Layoff

Last Day Worked/Dislocation Date: _____

CITIZENSHIP STATUS

☐ US Citizen
☐ Permanent Resident
☐ Non-Permanent Resident/Refugee
☐ Other: _____

LEGAL STATUS

☐ N/A
☐ I have been convicted of a felony or misdemeanor.
- ☐ Misdemeanor Date: _____ Offense: _____
- Date: _____ Offense: _____
- ☐ Felony Date: _____ Offense: _____
- Date: _____ Offense: _____

☐ I am currently on ☐ Probation until _____ ☐ Parole until _____

EDUCATIONAL STATUS

Highest school grade completed? _____
High School Diploma or Equivalent Received? ☐ Yes ☐ No
Attending any school? ☐ No ☐ Yes, Where? _____

Email: _____ Phone #: _____ Alternate Phone #: _____

FAMILY SIZE & RESIDENCE INFORMATION

My residence address is, _____
(Street Address)

_____
(City) (State) (Zip)

*I live at this address with the following individuals:

Name	Relation	Age
1.)	Self	
2.)		
3.)		
4.)		
5.)		
6.)		
7.)		

☐ Homeless: I currently lack a fixed, regular & adequate nighttime residence; or am living in a homeless shelter.

****OTHER**

☐ Additional Documents scanned into CalJOBS _____
Applicant Initials

SIGNATURE

I certify and attest, under the penalty of perjury that the information stated above is true and accurate to the best of my knowledge.

_____ _____
Applicant's Signature Date

**Reason for use of Applicant Statement for documentation: _____

_____ _____
Staff Signature Date

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WIOA DISABILITY APPLICANT STATEMENT

Applicant Name: _____ Last 4 of SSN: _____

DISABILITY STATUS

I am considered to have a disability:

☐ N/A ☐ Mental ☐ Physical ☐ Learning

During the last six (6) months, I or my family has received the following types of disability based income:

☐ N/A

☐ State Disability Insurance (SDI) ☐ Social Security Disability (SSDI)

☐ Supplemental Security Income (SSI) ☐ Worker's Compensation ☐ Other: _____

Do you have disability documentation? ☐ Yes ☐ No

Do you have doctor statements? ☐ Yes ☐ No

Do you have any physical limitations, mental limitations, learning limitations and/or restrictions that affect your ability to complete certain work functions? ☐ Yes ☐ No

Will an employer need to provide you special work accommodations? ☐ Yes ☐ No

If yes, what type of special work accommodations have been provided to you in the past?

_____

Are you taking any medications that affect your ability to complete certain work functions? ☐ Yes ☐ No

Are you able to stand for long periods of time? ☐ Yes ☐ No

Do you have a lifting restriction? ☐ Yes ☐ No

_____

I am able to lift _____ pounds repetitively.

Are you able to pass a drug screening? ☐ Yes ☐ No

_____
Applicant Initial

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Client Consent to Release Information Among Partnering Agencies/Parties

Client Name: _____ Date: _____

Last 4 of Social Security Card # _____

I,_____, understand that at times the Stanislaus County Workforce Development (SCWD) and its affiliated organizations need to receive and/or share information with partnering agencies. I hereby give consent for SCWD to receive and/or share information with partnering agencies, and/or entities **regarding my enrollment in services, training status, testing outcomes, job search progress, and/or employment.** I further understand that this consent form will be valid until I am exited from any SCWD follow up program or until I retract consent to release information.

Partnering Agencies/Entities may include:

- EDD co-enrolled program staff: TAA, Veterans Representative or YEOPS staff
- A Vocational Training Organization where I attend(ed) training
- Department of Child Support Services
- Community Services Agency
- Education services such as: Learning Quest, SCOE and Modesto Junior College where I attend(ed)
- SCWD's Contracted Services Organizations
- Employers
- Other (specify agency and what info may be shared/released):

_____

_____

THIS FORM WAS COMPLETED IN ITS ENTIRETY AND WAS READ BY ME PRIOR TO SIGNING.

_____ _____

Client Signature Date Staff Signature Date

SCWD/WIOA Nondiscrimination & Equal Opportunity Complaint Policy

The recipient of Federal financial assistance must comply fully with the nondiscrimination and equal opportunity provisions of the following laws and will remain in compliance for the duration of the award of Federal financial assistance.

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; 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 (WIOA), 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: deciding who will be admitted, or have access, to any WIOA Title I-financially assisted program or activity; providing opportunities in of 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. No qualified individual with a disability may be excluded from participation in, or denied benefits of a service, program, or activity or be subjected to discrimination by any recipient because a recipient's facilities are inaccessible or unusable by individuals with disabilities.

WHAT TO DO IF YOU BELIEVE YOU HAVE EXPERIENCED DISCRIMINATION

If you believe that you have been subjected to discrimination under a WIOA Title I financially assisted program or activity, you may file a complaint in writing using the Stanislaus County Workforce Development Discrimination Complaint Form within 180 days from the date of the alleged violation with:

Julie Mendoza, Equal Opportunity Officer (EEO)
Stanislaus County Workforce Development (SCWD)
P.O. Box 3389
Modesto, CA 95353-3389;
Email: MendozaJ@stanworkforce.com
Telephone: 209-303-3200
TTY for Hearing/Speech Impaired 1-800-735-2922

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 (CRC).

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 the CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

Client acknowledgment:

I have read or had this procedure explained to me. I understand that I can contact Stanislaus County Workforce Development Equal Opportunity Officer (EEO) for assistance if necessary. I am aware of my right to seek legal help from an attorney, lawyer or other persons at my own expense. I understand that neither I nor anyone who helped or assisted me can be threatened or suffer retaliation because I filed a Civil Rights complaint.

_____ _____
Client Name (Print) **Date:**

_____ _____
Client Signature **Date:**

_____ _____
Parent/Guardian Signature (17 years old or younger) **Date:**

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SCWD/WIOA Programmatic Grievance or Complaint Procedure

Your Rights

You have the right to inform Stanislaus County Workforce Development (SCWD) if you feel that at any time in the past year:

- You have not received promised WIOA services, or
- You feel that your SCWD program or service does not meet WIOA requirements.

Definition

Grievance or Complaint: A written expression by a party alleging a violation of WIOA Title I, regulations noted under WIOA, recipient grants, sub-grants, or other specific agreements under WIOA.

SCWD

Stanislaus County Workforce Development (SCWD), to include its One-Stop Centers (currently branded as America's Job Center of California), One-Stop Partners, youth and adult service providers, and the client's employer.

Who Can File

• Clients • Other Interested Parties

What It Means

WIOA demands a high-quality program meeting Federal standards. These include:

Job placement: • Wages • Benefits • Labor standards

WIOA: • Customer service • Program services • Training services

If you believe that SCWD is not providing the high-quality program that WIOA requires, please request to speak to a supervisor. A complaint submitted in writing will trigger a Local Level Hearing process.

When to File/Put In Writing (SCWD can provide technical assistance)

You have the right to file a grievance or complaint at any time within one year of the alleged violation. Please include:

- Full name and contact information for you and the other party involved.
- A short statement of the facts and dates describing the alleged violation
- and when it happened.
- Areas of WIOA, Federal regulations, grant, or other WIOA agreements violated.
- Who was involved, and how they violated WIOA law, regulation, or contract.
- The remedy you sought.
- The Grievance or complaint must be in writing, signed, and dated

Who to File to

Send to:

Julie Mendoza, Equal Opportunity Officer (EEO)
Stanislaus County Workforce Development
P.O. Box 3389
Modesto, CA 95353-3389
Email: MendozaJ@stanworkforce.com
Telephone: 209-303-3200
TTY for Hearing/Speech Impaired 1-800-735-2922

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When You File

Filing starts the Hearing process: SCWD will work informally to resolve your grievance before the Hearing. If the issue is not resolved informally, you will be notified (and invited) at least 10 days prior to a scheduled hearing.

The Hearing

The Local Hearing will be scheduled to take place within 30 days of filing: The Hearing Officer will be an impartial party. You may have witnesses and an attorney (at your own expense). The Hearing Officer will send the written decision of hearing no later than 60 days after the filing date of the filing. The hearing shall be recorded (either audio or visual), and transcribed.

Appeal

Conditions: You have 10 days after receiving a decision against you to appeal to the State. You have 15 days to appeal, if no decision is received within the 60-day limit, or you feel coerced or threatened. Your appeal must have your full name, telephone number, your mailing address, the mailing address of Stanislaus County Workforce Development, a statement reason why you are requesting an appeal or request for EDD review, local Hearing Officer's decision (if received), and copies of relevant documents. SCWD can provide technical assistance.

Send to: **Chief, Compliance Review Office, MIC 22-M**
Employment Development Department
P.O. Box 826880
Sacramento, CA 94280-0001

The Chief of Compliance Review (or their designee) will try to resolve the grievance informally prior to a formal Hearing. If the state cannot resolve the grievance or complaint informally (the state shall obtain and review transcripts from the local level hearing or if no local level hearing was held, then the Local Area will be directed to do so) a hearing will be held. The EDD Hearing will be held within 30 days of filing the grievance or complaint. A written decision will be sent out within 60 days of your appeal to the State.

Federal Appeal

You can file a final appeal to the U.S. Department of Labor if the State decision was against you or the State missed its deadlines. SCWD will provide you information for filing

I read or had this procedure explained to me. I know that I can contact my Case Manager for help. I can have help from an attorney or other persons at my own expense. I understand that neither I nor anyone who helps me can be threatened or suffer retaliation if I file a grievance or complaint.

_____ _____

Client Signature **Date**

CURRENT & PAST WORK EXPERIENCES

Name: ______________________________________ Last 4 of SS #: _________________

Please complete in INK. Starting with your most recent position, list all past work experience for the last 15 years for any paid and unpaid work. Please be complete and specify the duties and applied skills.

FROM _________________ TO_________________ HRLY WAGE $ ________ #HOURS/WEEK ___________
Month Year Month Year

EMPLOYER: ____ POSITION TITLE: _______________

ADDRESS: ____

DUTIES / SKILLS: ____

REASON FOR LEAVING: ____

FROM _________________ TO_________________ HRLY WAGE $ ________ #HOURS/WEEK ___________
Month Year Month Year

EMPLOYER: ____ POSITION TITLE: _______________

ADDRESS: ____

DUTIES / SKILLS: ____

REASON FOR LEAVING: ____

FROM _________________ TO_________________ HRLY WAGE $ ________ #HOURS/WEEK ___________
Month Year Month Year

EMPLOYER: ____ POSITION TITLE: _______________

ADDRESS: ____

DUTIES / SKILLS: ____

REASON FOR LEAVING: ____

I certify that the above statements are true, complete and correct to the best of my knowledge. I hereby authorize the representative of Stanislaus County Workforce Development to contact employers to verify my qualifications/work history.

_______________________________________ _______________________________________
Client signature Date

CURRENT & PAST WORK EXPERIENCES

Name: ________________________________ Last 4 of SS #: ______________

Please complete in INK. <u>Starting with your most recent position</u>, list all past work experience for the last 15 years for any paid and unpaid work. Please be complete and specify the duties and applied skills.

FROM ______________ TO______________ HRLY WAGE $ ________ #HOURS/WEEK __________
Month Year Month Year

EMPLOYER: ________________________________ POSITION TITLE: ______________

ADDRESS: ____

DUTIES / SKILLS: ____

REASON FOR LEAVING: ____

FROM ______________ TO______________ HRLY WAGE $ ________ #HOURS/WEEK __________
Month Year Month Year

EMPLOYER: ________________________________ POSITION TITLE: ______________

ADDRESS: ____

DUTIES / SKILLS: ____

REASON FOR LEAVING: ____

FROM ______________ TO______________ HRLY WAGE $ ________ #HOURS/WEEK __________
Month Year Month Year

EMPLOYER: ________________________________ POSITION TITLE: ______________

ADDRESS: ____

DUTIES / SKILLS: ____

REASON FOR LEAVING: ____

I certify that the above statements are true, complete and correct to the best of my knowledge. I hereby authorize the representative of Stanislaus County Workforce Development to contact employers to verify my qualifications/work history.

______________________________ ______________________________
Client signature Date

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Job Search Log

Name:			Employment Goal:				
Date Applied	**Job Title**	**Company Name**	**How did you apply? (ex: Indeed, CalJOBS; in person or on company website)**	**Date you received confirmation:**	**Interview (Y/N) & Date:**	**Date you followed up:**	**Selection Decision: (Testing, Not hired, 2nd Interview)**

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Job Search Log

Name:			Employment Goal:				
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