

# Workforce Grants Application

Apply now! Submit form to Lewis Hall L-116 or via email at [WorkforceGrants@skagit.edu](mailto:WorkforceGrants@skagit.edu)

**Please submit the following required documentation with your application:**

- WA State Drivers License or ID Card;
- Income Verification (one of the following)
  - DSHS Basic Food Award Letting \*must provide if receiving\*
  - A minimum of 4 most recent consecutive pay-stubs for household
- WA Unemployment payment history from SAW Account

**STAFF ONLY:**

Date Received: \_\_\_\_\_

Received by: \_\_\_\_\_

Before applying, learn more  
**WORKFORCE GRANTS  
 INFORMATION SESSIONS**  
**Date:** 1st Wednesday each month  
**Time:** 11:30am - 12:30am  
**Where:** Zoom  
<https://skagitvalleycollege.zoom.us/j/97770490851>

## Student Profile & Contact Information

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

ctcLink ID#: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ May we contact you via text?  Yes  No

Address (Street, City, State, Zip): \_\_\_\_\_

## Household Size

List **all** household members below (not including yourself):

	Name:	Age:	Relationship to you:
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

\*NOTE: Household size generally includes you plus the people who live with you and depend on shared income—such as your spouse, your children you support, and others included on your tax return.\*

### FOR STAFF USE ONLY

<input type="checkbox"/> WA State Drivers License/ID <input type="checkbox"/> Income: <input type="checkbox"/> DSHS Food <input type="checkbox"/> UI <input type="checkbox"/> Pay Stubs <input type="checkbox"/> Applied for FAFSA/WASFA <input type="checkbox"/> Pell Grant <input type="checkbox"/> WA College Grant <input type="checkbox"/> Other Funding: _____  Program: _____	Program(s): <input type="checkbox"/> BFET <input type="checkbox"/> OG <input type="checkbox"/> WRT <input type="checkbox"/> WF <input type="checkbox"/> EAG <input type="checkbox"/> CIP  Notes:
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## Income Information

What is your household gross **monthly** income? \$ \_\_\_\_\_ Household size (including self): \_\_\_\_\_

Sources of income:  Employment  DSHS  Social Security  Unemployment  Disability

My income is \$0, to support myself I: \_\_\_\_\_

## Program Specific Eligibility

Are you a United States Citizen?  Yes  No

Are you an eligible Non-Citizen/Permanent Resident?  Yes  No # A- \_\_\_\_\_ (submit card)

Are you currently receiving aid from any of the following?

DSHS Food Benefits  DSHS TANF Cash  Unemployment Benefits - If yes, start date: \_\_\_\_\_

Previously received WA Unemployment in the last 48 months?  Yes  No If yes, end date: \_\_\_\_\_

Are you Previously Self-Employed - was self-employed but is now unemployed as a result of general economic conditions in the community or because of natural disaster?  Yes  No

Have you been divorced, separated, or widowed?  Yes  No

Are you a United States Armed Forces Veteran discharged within the last 40 months?  Yes  No

Have you received Opportunity Grant at Skagit Valley College or at another college?  Yes  No

Have you completed a Financial Aid Application (FAFSA/WASFA) for this year?  Yes  No

Are you receiving Federal Financial Aid (Pell Grant, WA College Grant) for school?  Yes  No

Have you received Federal Education Loans before?  Yes  No

If YES, what is the status of your loan? \_\_\_\_\_

## Employment History

Employer: \_\_\_\_\_  Part-Time (1-31 hours)  Full-Time (32+ hours)

Job Title: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Employer: \_\_\_\_\_  Part-Time (1-31 hours)  Full-Time (32+ hours)

Job Title: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Are you currently employed at an Early Achievers eligible site:  Yes  No STARS #: \_\_\_\_\_

## Education History

Do you have a High School Diploma/GED?  High School Diploma  GED Date Earned: \_\_\_\_\_

What is the highest grade level you have completed (if no High School Diploma): \_\_\_\_\_

What is your first language?  English  Spanish  Ukrainian  Russian  Other: \_\_\_\_\_

If applicable: Please select the programs below that you are currently enrolled in:

GED Program  ELA  CCB  High School Completion

Have you attended any other Higher Education Institutions?  Yes  No

If yes, please fill out the school information below:

Name of School: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Degree/Program: \_\_\_\_\_ City/State: \_\_\_\_\_

Type of Degree/Program:  Cert  Associates  Bachelors+ Completed?  Yes  No

Name of School: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Degree/Program: \_\_\_\_\_ City/State: \_\_\_\_\_

Type of Degree/Program:  Cert  Associates  Bachelors+ Completed?  Yes  No

## Education Goals

Which program of study are you interested in, or currently are, pursuing?

**Degree/Program Type:**  Bachelors  Associates  Certificate  ELA/GED/HSD

**Program/Area of Study:**  Automotive  Business Management  Culinary  
 Diesel  Early Childhood Ed  Fire/EMT  
 Human Services  Marine Maintenance  Medical Assisting  
 Medical Billing & Coding  Nursing/CNA  Welding  
 Other: \_\_\_\_\_

Which quarter do you intend to start your program?

Summer  Fall  Winter  Spring Year: \_\_\_\_\_

Do you intend to transfer to a 4-year university?  Yes  No

If yes, which institution: \_\_\_\_\_ Major: \_\_\_\_\_

Do you plan to work while attending college?  Yes  No Frequency:  Full-Time  Part-Time

Do you have reliable transportation for attending training?  Yes  No





Client Identification			
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION		



## Consent

**Notice to Clients:** The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

### Consent

1. I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I also grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, by mail, or hand delivery.

**Reason for Disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.**

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- Health care providers: \_\_\_\_\_
- Mental health care providers: \_\_\_\_\_
- Substance use disorder service providers: \_\_\_\_\_
- Other DSHS contracted providers: \_\_\_\_\_
- Housing programs: \_\_\_\_\_
- School districts or colleges: **Skagit Valley College (SVC)** \_\_\_\_\_
- Department of Corrections: \_\_\_\_\_
- Employment Security Department and its employment partners: \_\_\_\_\_
- Social Security Administration or other federal agency: \_\_\_\_\_
- See attached list
- Other: \_\_\_\_\_

2. Reason for disclosure:  Continuity of care  Legal  Personal  Other:

3. I authorize and consent to sharing the following records and information (check all that apply):

- All my client records  Records on attached list
- Only the following records
  - Family, social and employment history
  - Treatment or care plans
  - Payment records
  - Individual assessments
  - School, education, and training
  - Mental health care information (specify): \_\_\_\_\_
  - Health care information (specify): \_\_\_\_\_
  - Other (list): \_\_\_\_\_

Client Identification		
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER
<p><b>Please note: If your client records include any of the following information, you must also complete this section to include these records.</b></p> <p>I give my permission to disclose the following records (check all that apply):</p> <p><input type="checkbox"/> Mental health      <input type="checkbox"/> HIV/AIDS and STD test results, diagnosis, or treatment      <input type="checkbox"/> Substance Use Disorder</p> <ul style="list-style-type: none"> <li>• This consent is valid for one-year or <input checked="" type="checkbox"/> until <u>Completion of program study at SVC</u> (date or event).</li> <li>• I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.</li> <li>• I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.</li> <li>• A copy of this form is valid to give my permission to share records.</li> </ul>		
SIGNATURE		DATE
WITNESS / NOTARY SIGNATURE, IF APPLICABLE	WITNESS / NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE
<p>If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)</p> <p><input type="checkbox"/> Parent      <input type="checkbox"/> Legal Guardian (attach court order)      <input type="checkbox"/> Personal representative      <input type="checkbox"/> Other:</p>		

**Notice to Recipients of Information:** If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

## Instructions for Completing the Consent Forms, DSHS 14-012

**Use:** Use this form when you need consent to use or share confidential information about a client on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law.

Fill out this form electronically if possible. You must complete **a separate form for each person, including children.** .

### Parts of Form:

#### IDENTIFICATION:

- Name: Provide the name of only one client on each form. Include any former names that client may have used when receiving services.
- Date of Birth: Needed to identify client from persons with similar names.
- Identification Number: Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- Other: Include in this box any additional information that may help to locate records, such as DSHS involved with services, names of family members, or other relevant information.

#### CONSENT (AUTHORIZATION):

- Reason for disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.
- Agencies or persons exchanging records: This completed form allows: (1) the use and disclosure of confidential information inside DSHS and with the agencies or persons listed; and (2) disclosure of confidential information to DSHS by the outside agencies or persons listed. You may also attach a list of agencies allowed to share information, which the client must also sign.
- Information included: Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii); a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent, if different than one year. The consent will expire in one year unless you identify a different date.
- Understanding: Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit.

#### SIGNATURES:

- Client: Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- Witness or Notary: A witness or notary may be needed to verify the client's identity if the client does not submit this form in person or if a program requests verification. This person should sign and print his or her name.
- Parent or Other Representative: If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark "other" and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.