Workforce Grants Application

Apply Now! Submit form to Lewis Hall 116

Skagit Valley College

Date Received: _____

Complete this form. We need to determine your eligibility.
Please answer ALL questions. Your information will be kept confidential.
If you need help in completing this application, please call us at (360) 416-7971.

Submit the following required documentation with the application:

- ☐ WA State License or ID card;
- ☐ Income verification (as it may apply):
  - ° Most recent tax forms; proof of parents and/or spouse's income OR
  - ° Most recent W-2 OR
  - ° A minimum of four consecutive, recent check-stubs
- ☐ If receiving Basic Food through DSHS: must provide Basic Food Award letter
- ☐ If receiving WA Unemployment Insurance: must provide Unemployment payment history from SAW account

Before applying, learn more:
WORKFORCE GRANTS INFORMATION SESSIONS

Date: 1st Wednesday each month
Time: 11:30am – 12:30pm
Where: Work Source Skagit, Room 101

STUDENT PROFILE & CONTACT INFORMATION

NAME: _____
Last First MI

Social Security #: _____ SVC Student ID #: _____

Address: _____
Street City State Zip Code

Home Phone #: _____ Cell Phone Provider: _____

Cell Phone #: _____ May we contact you via text message? ☐ Yes ☐ No

Email: _____ Sex: ☐ Male ☐ Female Birth Date: _____

Your social security number is confidential and, under a federal law called the Family Educational Rights & Privacy Act, the college will protect it from unauthorized use and/or disclosure. In compliance with state/federal requirements, disclosure may be authorized for the purposes of state and federal financial aid, Hope/Lifetime Learning tax credits, academic transcripts, assessment or accountability research.

PROGRAM ELIGIBILITY

Are you receiving aid from the following? Please check all that apply: ☐ DSHS Food Benefits ☐ DSHS TANF Grant/WorkFirst

Are you currently receiving Unemployment Benefits? ☐ Yes ☐ No If yes, start date? _____

Have you received WA unemployment Benefits in the last 48 months? ☐ Yes ☐ No If yes, Start Date_____ End Date_____

Are you a U.S. citizen? ☐ Yes ☐ No

Eligible non-Citizen/Permanent Resident? ☐ Yes ☐ No Registration #: A-_____ (please attach copy of card)

Are you HB1079 eligible? ☐ Yes ☐ No

How long have you lived **continuously** in Washington state? _____ Year(s) _____ Month(s)

Have you received Opportunity Grant at another college? ☐ Yes ☐ No

Have you completed a financial aid application (FAFSA/WASFA) **for this (current) year**? ☐ Yes ☐ No

Are you receiving federal financial aid for school such as a Pell Grant or State-Need Grant? ☐ Yes ☐ No

Have you received federal educational loans before? ☐ Yes ☐ No

If YES, what is the status of your loan? _____

OFFICIAL NOTES/FOR STAFF USE ONLY:	FAM:	NOTES:
CASAS APPRAISAL SCORE: R ____; M____	CWPA REFERRAL: YES ☐ No ☐	
❒ WA STATE DRIVER'S LICENSE/ID	I-BEST: YES ☐ No ☐	
❒ SS CARD	PROGRAM:	
❒ INCOME VERIFICATION: TAX FORMS /W-2/CHECK STUBS/ UI/DSHS	BFET ☐ EAG ☐ I-CATCH ☐ OG ☐ WRT ☐ WF ☐ CIP ☐	
❒ FAFSA SAR/ AWARD LETTER	INTAKE DATE:	

Your family's monthly gross income: $ _____

Household size reported (include yourself): _____ Number of school aged children: _____

Source of income: ☐Employment ☐DSHS ☐Social Security ☐Unemployment Benefits ☐Disability
☐Other, please explain _____

If you are claiming zero income, how do you support yourself? Please explain: _____
_____

HOUSEHOLD MEMBERS: NAME AGE RELATIONSHIP TO YOU

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

EDUCATIONAL HISTORY:

Is English your first language? ☐Yes ☐No If NO, what is your first language? _____

Do you have a High School Diploma or GED? ☐Yes ☐No Date Earned: _____

What is the highest grade-level that you have completed? _____

If you are currently enrolled in any of the following check all that apply: ☐ GED ☐ High School Completion ☐ELA ☐ CCB

Have you attended any other higher education institutions? ☐Yes ☐No

If yes, please fill out the school information below:

Name of School _____ Start/End Dates: _____
Type of Training _____ City/State: _____
Completed: ☐Yes ☐No

Name of School _____ Start/End Dates: _____
Type of Training _____ City/State: _____
Completed: ☐Yes ☐No

EDUCATIONAL GOALS: (PROGRAM INTENT) Which program of study are you interested in, or currently are, pursuing?

☐ Allied Health Education ☐Welding ☐Early Childhood Education ☐Automotive ☐Manufacturing ☐Marine Maintenance
☐Human Services ☐Certified Nursing Assistant ☐Medical Assistant ☐Other: _____

What degree/certificate are you seeking at Skagit Valley College?
☐ Associate (transfer to a four-year university) _____ ☐Certificate (less than 2 years): _____
☐Associate (professional/technical) _____ ☐Undecided _____

What quarter do you intend to start your program? Summer☐ Fall☐ Winter☐ Spring☐ Indicate year: _____

Do you plan to transfer to a FOUR-YEAR College or University? ☐Yes ☐No
If **YES,** intended transfer institution: _____ **Major:** _____

****** Please remember to include the required documentation with this WorkForce Grants Application upon submission. Thank you! ***** ***Updated: 10/2019***

EMPLOYMENT HISTORY:

1. Employer: _____ Part-Time ☐ Full-time ☐

Job Title: _____ Dates: _____

City/State: _____

Job Duties: _____

_____

_____

Reason for Leaving: _____

2. Employer: _____ Part-Time ☐ Full-time ☐

Job Title: _____ Dates: _____

City/State: _____

Job Duties: _____

_____

_____

Reason for Leaving: _____

Are you currently employed by an Early Achievers Child Care Provider or own an Early Achievers site? ☐Yes ☐No

SUPPORT NEEDS: How can Workforce Grants best support your educational goals? Check all that apply:

☐Academic Advising ☐Career Development/Counseling ☐Cultural Activities
☐Financial Aid Advising ☐Personal Counseling/ Support ☐Tutoring
☐Mentoring ☐Childcare ☐Study Skills
☐Transfer Advising ☐Disability Access Services ☐Other _____

How did you find out about Workforce Grant Education/Funding? _____

Are you receiving any support from another program? It is important to check all that apply:

☐ Child Care Aware/WA Scholars ☐DSHS Basic Food ☐DVR ☐Trio ☐WorkFirst ☐Worker Retraining
☐ WorkSource ☐Other _____

Affidavit of Truth Statement and Release of Information

The information provided on this form is, to the best of my knowledge, accurate and true. I understand that by applying for a Workforce Grant or Program, I authorize program staff to obtain and share records or data pertinent to my participation from other campus offices and/or the Washington State Board of Community and Technical Colleges. I understand that all information will be protected as confidential. I understand that I am not eligible to receive Workforce Grants Program services until the application process is complete.

Your Signature: _____ **Date:** _____

Skagit Valley College provides a drug free environment and does not discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, disability, or age in its programs and employment. The following person has been designated to handle inquiries regarding the nondiscrimination policies: Executive Director of Human Resources, 2405 East College Way, Mount Vernon, WA 98273, 360.416.7794

****** Please remember to include the required documentation with this WorkForce Grants Application upon submission. Thank you! ***** *Updated: 10/2019*

Please write a <u>minimum of three sentences (or the length otherwise indicated)</u> in response to each of the following questions. This section must be completed by the applicant to be considered for the different grant programs and services offered through WorkForce Grants. Attach additional paper if needed.

1. What are your academic goals at Skagit Valley College? Include which program of study you are pursuing and why you have chosen that pathway. **(*response must be a minimum of <u>3</u> sentences*)**

2. What is your employment goal for when you complete your chosen program? Please be specific. **(*response must be a minimum of <u>3</u> sentences*)**

3. What concerns do you have about reaching your educational goals? (time, childcare, financial, difficulty, transportation, medical, etc.) **(*response must be a minimum of <u>3</u> sentences)***

4. What is your financial plan to complete your program if your funding runs out before you finish training?

5. Do you plan to work while attending Skagit Valley College? Yes ☐ No ☐
   Full-time ☐
   Part-time ☐

6. Do you have reliable transportation for attending training? Yes ☐ No ☐

7. Please write a personal statement detailing your current **housing situation** (i.e. renting, buying, staying with friends or family, etc.), **childcare** arrangements (if applicable), and **transportation**. **(*response must be a minimum of 3 sentences*)**

Washington State Department of Social & Health Services
Transforming lives

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.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION

CONSENT:

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 further 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 by computer data transfer, mail, or hand delivery.

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: _____
- ☐ Chemical dependency 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:

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
  - ☐ Payment records
  - ☐ Other (list):
  - ☐ Health care information
  - ☐ Individual assessments
  - ☐ Treatment or care plans
  - ☒ School, education, and training

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Chemical Dependency (CD) services

- This consent is valid for ☐ one year ☐ as long as DSHS needs records, or ☒ until Completion of program of study at SVC (date or event).

- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.

- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.

- A copy of this form is valid to give my permission to share records.

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

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 medial 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 COMPLETION OF CONSENT FORM

Purpose: Use this form when you need consent to use confidential information 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. Clients are persons receiving benefits or services from DSHS.

Use: Fill out this form electronically if possible for ease of reading, **A separate form must be completed for each person, including children.** "You" in the instructions refers to the DSHS employee and "you" on the form refers to the client. Sharing of records includes the use and disclosure of confidential information about a client.

Parts of Form:

IDENTIFICATION:

- Name: Provide the name of one client only 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.
- Address and telephone: Additional information that will help in locating and identifying or contacting the client.
- Other: Include in this box any additional information that may help to locate records that may include parts of DSHS involved with services, names of family members, or other relevant information.

CONSENT (AUTHORIZATION):

- Agencies or persons exchanging records: The client's completion of this form allows the use and sharing of confidential information within all of DSHS. DSHS will be able to disclose to and receive confidential information from the outside agencies or persons listed. Provide identifying information about the agencies or providers, including name, address or location if possible. 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) and a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent that serves your program purposes or as provided by law.
- 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.
- Agency Contact or Witness: You will sign in this box if you are the one presenting and explaining the form to the client. Please include your telephone number. If the client will be signing the form away from a business site, instruct the client to have a witness sign in this block and provide a telephone number. A notary public may serve as a witness to a client signature.
- 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.