UNDERSERVED COVID-19 APPLICANT STATEMENT

APPLICANT NAME: _____

INCOME

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)

2019 ANNUAL 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: _____

COVID-19 RELATED ELIGIBILITY CRITERIA

☐ **Laid off due to COVID-19 or**	☐ **Reduction in hours and/or pay or**
Unable to work due to one of the following:	
☐ **Self-Quarantine**	
☐ **Caregiver for someone subject to quarantine**	
☐ **Care for children due to school closure or another child care provider**	
☐ **At high risk of getting ill**	
☐ **Required to telework, but does not have the necessary equipment**	

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.

****Explain the request and need for the supportive service:**

☐ 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

STANISLAUS COUNTY WORKFORCE DEVELOPMENT

A proud partner of America's JobCenter of California℠

Stanislaus County Workforce Development

Client Consent to Release Information Among Partnering Agencies/Parties

Client name: _____ Date: _____

I, _____ , understand that at times Stanislaus County Workforce Development (SCWD) needs to receive and/or share information with partnering agencies. I hereby give consent for the Workforce Development 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 Workforce Development 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
- Vocational Training Center where I attend(ed) training
- Department of Child Support Services
- Community Services Agency
- Adult Education services such as: Learning Quest, SCOE and Community Business College where I attend(ed)
- Friends Outside
- 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	SCWD staff signature	Date
_____	_____	_____	_____

For the purpose of client confidentiality, if highlighted section references medical and disability-related information, please remove this form and attachments from case file and place in separate confidential file.

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 decision 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:

Aimee Meza, Equal Opportunity Officer (EEO)
Stanislaus County Workforce Development (SCWD)
P.O. Box 3389
Modesto, CA 95353-3389;
Email:MezaA@stanworkforce.com
Telephone: 209-604-1667
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 acknowledgement:

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.

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

_____ _____
Participant Signature **Date:**

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

STANISLAUS COUNTY WORKFORCE DEVELOPMENT

SCWD/WIOA Programmatic Grievance or Complaint Procedure

Your Rights

You have the right to tell 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 participant's employer.

Who Can File

- Participants
- 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.

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.

Who to File to

- The Grievance or complaint must be in writing, signed and dated

Send to:

Aimee Meza, Equal Opportunity Officer (EEO)
Stanislaus County Workforce Development
P.O. Box 3389
Modesto, CA 95353-3389
Email: MezaA@stanworkforce.com Telephone: 209-604-1667
TTY for Hearing/Speech Impaired 1-800-735-2922

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 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 of 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.

_____ _____

Participant Signature **Date**