Workforce Grants Application

Apply Now! Submit form to Lewis Hall L-116
or via email at WorkforceGrants@skagit.edu

Skagit Valley College

Date Received: _____

Please submit the following required documentation with your application:

- ☐ WA State Drivers License or ID Card;
- ☐ Income Verification
  - A minimum of 4 recent consecutive pay-stubs
  - Most recent tax forms or W-2
  - Proof of parents/spouses' income
- ☐ DSHS Basic Food Benefits Award Letter must be provided if receiving
- ☐ WA Unemployment payment history from SAW Account if received

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

Name: _____ Birth Date: _____

Address: _____

ctcLink ID #: _____ Cell Phone: _____

Social Security #: _____ Home Phone: _____

Email: _____ May we contact you via text? ☐ Yes ☐ No

Education Goals:

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

☐ CNA/Nursing ☐ Automotive ☐ Business Management ☐ Culinary
☐ Medical Assisting/Billing ☐ Early Childhood Ed ☐ Marine Maintenance ☐ Fire/EMT
☐ Human Services ☐ Welding ☐ Other: _____

Which degree/certificate are you seeking at Skagit Valley College?

☐ Associate Transfer: _____
☐ Associate Professional/Technical: _____
☐ Certificate: _____
☐ Other/Undecided: _____

Which quarter do you intend to start your program?

☐ Summer ☐ Fall ☐ Winter ☐ Spring Indicated year: _____

Do you plan to transfer to a FOUR-YEAR College or 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

REMINDER: PLEASE TURN IN ALL NECESSARY SUPPLEMENTAL DOCUMENTATION IN ORDER FOR YOUR APPLICATION TO BE REVIEWED

Education History:

Do you have a high school diploma or a GED? ☐ Yes ☐ No Date earned: _____

What is your first language? ☐ English ☐ Spanish ☐ Russian ☐ Other: _____

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 ☐ 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: _____

Type of training: _____ City: _____ State: _____

Completed: ☐ Yes ☐ No

Name of School: _____ Start Date: _____ End Date: _____

Type of training: _____ City: _____ State: _____

Completed: ☐ Yes ☐ No

Employment History:

Employer: _____ ☐ Part-Time (31 hours or less) ☐ Full-Time (32 hours or more)

Job Title: _____ Start Month/Year: _____ End Month/Year: _____

City/State: _____

Job Duties:

Reason for leaving: _____

Employer: _____ ☐ Part-Time (31 hours or less) ☐ Full-Time (32 hours or more)

Job Title: _____ Start Month/Year: _____ End Month/Year: _____

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

REMINDER: PLEASE TURN IN ALL NECESSARY SUPPLEMENTAL DOCUMENTATION IN ORDER FOR YOUR APPLICATION TO BE REVIEWED

Program Eligibility:

General Eligibility Questions:

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

Are you currently receiving unemployment benefits: ☐ Yes ☐ No If yes, start date: _____

Have you received WA Unemployment in the last 48 months? ☐ Yes ☐ No Start Date: _____ End Date: _____

Are you a US Citizen? ☐ Yes ☐ No

Are you an eligible non-Citizen/Permanent Resident? ☐ Yes ☐ No Registration # A- _____ (please submit card)

Are you HB1709 Eligible? ☐ Yes ☐ No

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

Are you a United States Armed Forces Veteran? ☐ Yes ☐ No

Are you currently considered to be in Foster Care? ☐ Yes ☐ No

Are you currently experiencing homelessness? ☐ Yes ☐ No

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 Washington College Grant? ☐ Yes ☐ No

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

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

Income Eligibility:

Please list all household members below:

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

What is your family's monthly gross income? $ _____

What is your household side reported (including yourself)? _____ Number of school age children: _____

Source(s) of income: ☐ Employment ☐ DSHS ☐ Social Security ☐ Unemployment Benefits ☐ Disability ☐ Other: _____

If you are claiming zero income, how do you support yourself?

Support Needs Assessment:

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 hear about Workforce Grant Education/Funding? _____

Are you receiving any support from another program? Check all that apply:

- ☐ Childcare Aware
- ☐ WorkSource
- ☐ DVR
- ☐ Trio
- ☐ WorkFirst
- ☐ Worker Retraining
- ☐ Other: _____

Below are some long-answer questions. Please write a minimum of two sentences (or the length otherwise indicated) 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.

2. What is your employment goal for when you complete your chosen program? Please be specific.

3. What concerns do you have about reaching your educational goals (time, childcare, financial, transportation, medical, etc.)?

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

5. Please write a personal statement detailing your current housing situation (rent, buying, staying with a friend, etc), childcare arrangements (if applicable), and transportation. (response must be a minimum of three sentences)

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.

If you are signing this electronically, this application must be sent via email from your Skagit Valley College student email address only.

Applicant Signature: _____ Date: _____

Parent/Legal Guardian (If Applicant is Under Age 18): I certify by my signature below that the information provided in this application is correct to the best of my knowledge and that, if accepted, my dependent may participate in employment and training programs.

Parent/Legal Guardian Signature: _____ Date: _____

OFFICIAL NOTES/FOR STAFF USE ONLY:

- ☐ WA State Drivers License/ID
- ☐ Income: Tax Forms/W-2/CHECK STUBS/UI/DSHS
- ☐ Receiving DSHS Federal Basic Food Benefits
  - ☐ Submitted Food Award Letter
- ☐ Applied for FAFSA/WASFA
  - ☐ Awarded Pell ☐ Awarded WA College Grant
  - ☐ Awarded other funding: _____

Program of study: _____

Program eligibility assessment:

☐ BFET ☐ OG ☐ EAG ☐ WRT ☐ JCS ☐ WF

Notes:

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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.