

COMMUNITY ACTION PARTNERSHIP of NORTHWEST MONTANA

Main Office

214 Main Street
PO Box 8300
Kalispell, MT 59904
T: 758-5454 F: 752-6582

Libby Outreach Office

933 Farm to Market Rd., Suite B
Libby, MT 59923
T: 293-2712
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COMMUNITY ACTION PARTNERSHIP ADULT PROGRAM

The goal of Community Action Partnership of Northwest Montana (CAPNM) WIA Title IB, Adult Program is to provide Core, Intensive and Training services to individuals seeking to manage their career needs with access to information and high quality services. This program is intended to empower individuals *18 and older* who are at or lower than a level of self-sufficiency through better integration of services and meaningful labor market information (employment statistics) so that individuals can make informed choices about their careers.

All Montana adults are eligible for Core services. Core services include self-help services and services requiring minimal staff assistance.

Intensive and training services may be provided to adults that have been determined to be in need of these services in order to obtain employment, or obtain and retain employment that allows for self-sufficiency. Intensive services may be available to adults who have completed one or more Core Service(s) and are still unable to gain employment or who are employed and have been determined in need of services to get a better job in order to gain self-sufficiency. Intensive services may include individual career planning, resume preparation, career counseling and comprehensive assessments.

Training services may be available for adults who have met the eligibility requirements for intensive services in order to obtain employment. Training services are limited to individuals who are unable to obtain other grant assistance for services, including federal Pell grants. The major emphasis of all services will be to assist those individuals who meet the eligibility and other criteria contained in the Workforce Investment Act (WIA) Manual, in achieving economic self-sufficiency through entry into unsubsidized employment. Training services may include but are not limited to a paid work-experience or occupational skills training. We concentrate on finding employment and training opportunities in areas that will allow Adults to improve our environment and promote the health and well being of our communities.

Income priority of service will be given to those who meet the 80% of Self-Sufficiency Priority of Service Eligibility Verification guidelines (see page 3). Additional Priority of Service will be given to Veterans and Eligible Spouses, Older Workers and those who face a Language Barrier, or face a Cultural Barrier.

CAP WIA Adult Program is an Equal Opportunity Provider and Employer.

• This program is NOT an entitlement program. Due to funding limitations, not everyone who is deemed eligible, will be enrolled in this program. Questions? Call 752-6565

List of Documents Required for Eligibility

The following information and documents are required in order to determine eligibility:

• **Copies of documents must be sent in or brought to the CAP Agency with the application. Any required documents not sent in with the completed application will be required before you can be determined eligible for this program.**

✓ **Application with Release Forms, signed with all appropriate signatures**

- ☐ Emergency Contact Release Form
- ☐ Equal Opportunity Form

✓ **Income**

☐ **One Person household currently employed, and making less than \$7.92 an hour is automatically income eligible. If more than one person in household refer to Income table on page 3.**

☐ **Categorically Income Eligible if receiving TANF cash assistance, food stamps/Commodities or Medicaid - (Social Services award letter, Benefit or Medicaid Card)**

✓ **Proof of ALL Family Income for the past 26 Weeks (6 Months)**

- ☐ Most recent paycheck stub(s)
- ☐ Employer Statement
- ☐ Copy of Social Security check or award letter
- ☐ Farm/business records
- ☐ Retirement income statement, check, or bank statement
- ☐ Public Assistance records
- ☐ Statement of Self-Employment income showing income and expenses
- ☐ Applicant Statement

✓ **Proof of Age - One of the following**

- Birth Certificate
- DD-214
- Baptismal Certificate
- Public Assistance Record
- School/State ID card
- Current US Passport
- Native American Tribal Document
- Driver's License or Learner's Permit
- Hospital Record of Birth
- Work Permits

✓ **Proof of United States Citizenship - One of the following**

- Birth Certificate
- Current US Passport
- Certification of Naturalization
- DD-214(if place of birth is listed)
- Alien Registration Card
- Hospital Record of Birth
- Public Assistance/Food Stamp records
- Baptismal Certificate (if place of birth is listed)
- Native American Tribal Document
- Foreign Passport (marked eligible to work)

✓ **Social Security Number Verification - One of the following**

- Social Security Card
- DD-214
- Social Security Administration Document (with participant's name and SSN)

Eligibility Guidelines for the Community Action Partnership
Adult Program

CAP ADULT PROGRAM services are open to Flathead & Lincoln County residents, age 18 and older who are determined to be **low income**.

1. WIA Adult Program Income Guidelines

FAMILY is defined as two or more persons related by blood, marriage or decree of court, which are living in a single residence. An adult is categorically income eligible if receiving TANF Cash assistance, Food Stamps/Commodities or Medicaid.

Family Size	Annual Non-Metro Area	6 Months Non-Metro Area
1	\$10,890*	\$ 5,445*
2	\$15,036	\$ 7,518
3	\$20,644	\$10,322
4	\$25,481	\$12,740
5	\$30,073	\$15,036
6	\$35,172	\$17,586

****Explanation of Income Table***

The table is a combined listing of 70 percent of Lower Living Standard Income Levels (LLSIL) and OMB Poverty Guidelines. The figures are annualized (12-month) incomes. The figure marked with an asterisk () is from the poverty guidelines published by Health and Human Services; the remainder is from LLSIL figures for non-metro areas.*

2. WIA ADULT PRIORITY FOR SERVICE

All Adults must meet the income eligibility criteria in order to be enrolled in the WIA Title I Adult program. Priority for services shall be given to recipients of public assistance and low-income. Further consideration may be given to individuals who are at less than 80% of self-sufficiency (**80% is currently \$7.92/hr**) and have a barrier to self-sufficiency such as:

- Veteran; or
- Spouse of a Veteran; or
- Are older workers (55+); or
- Face language barriers; or
- Face cultural barriers; or
- Other individuals who are not receiving services from other programs in WIA

CAP ADULT SERVICES PROGRAM APPLICATION

GENERAL INFORMATION:

DATE: _____

Last Name _____ First Name _____ M.I. _____

Social Security # _____ - _____ - _____ Date of Birth _____/_____/_____

Street Address _____ Mailing Address _____

City _____ State _____ Zip Code _____ County _____

Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Message Phone: (_____) _____ - _____ Additional Cell Phone (_____) _____ - _____

Sex: Male _____ Female _____ E-mail Address: _____

Are you a US Citizen? Yes ___ No ___ if not, are you authorized to work in the United States Yes ___ No ___
Explain, please: _____

ETHNICITY: White (not Hispanic) Black or African American Hispanic or Latino
 Alaskan/American Indian Asian (not Hispanic) Hawaiian/Pacific Islander Other

Note: Ethnicity question is voluntary. Information will be kept confidential and is intended for use solely in connection with record keeping and affirmative action requirements. You will not be penalized for refusal to answer.

EDUCATION:

Are you currently in school? Yes ___ No ___ please circle your grade level 7 8 9 10 11 12 13 14 15 16

What school are you (or were you) attending? _____

High School Dropout: Yes _____ No _____ in what grade? _____ in what year? _____

Receive a High School Diploma or GED? Yes _____ No _____

Attend Vocational School? Yes _____ No _____ Attend/Attending College? Yes _____ No _____

Years of Post Secondary Education Completed 13 14 15 16 16+ Degree? _____

ADDITIONAL INFORMATION (please complete as this information assists in the eligibility process):

Do any of the following pertain to you?

Are you pregnant? Yes ___ No ___ Are you a parent? Yes ___ No ___ If yes, how many children? _____

Have you ever been involved with the Justice System, Probation System or convicted of any crime except for minor traffic violations? Yes _____ No _____ If yes, who is your probation officer?

Do you have a valid Montana driver's license? Yes ___ No ___ If not Montana, what state? _____

What is your mode of transportation to a job or appointment? Public Transportation _____

Own Car _____ Other _____

Were you referred to the WIA program through Unemployment Insurance Yes ___ No ___

Registered with Job Service? Yes ___ No ___ Registered with Selective Service? Yes ___ No ___ **

****If No, you MUST be registered for the Selective Service in order to participate.**

Please list all people living in the household who are *related to the applicant by blood, marriage, or adoption*, their age, relationship to the applicant, and their gross earnings, if any, from the previous 6 months.

PLEASE INCLUDE YOURSELF ON THE FIRST LINE!

Documentation of the income may be sent with this application or must be provided at the eligibility interview.

1. Name _____	Age _____	Relationship _____	SELF
Social Security # _____ - _____ - _____	Earnings \$ _____	per wk/mo	
2. Name _____	Age _____	Relationship _____	
Social Security # _____ - _____ - _____	Earnings \$ _____	per wk/mo	
3. Name _____	Age _____	Relationship _____	
Social Security # _____ - _____ - _____	Earnings \$ _____	per wk/mo	
4. Name _____	Age _____	Relationship _____	
Social Security # _____ - _____ - _____	Earnings \$ _____	per wk/mo	
5. Name _____	Age _____	Relationship _____	
Social Security # _____ - _____ - _____	Earnings \$ _____	per wk/mo	
6. Name _____	Age _____	Relationship _____	
Social Security # _____ - _____ - _____	Earnings \$ _____	per wk/mo	

Household size including yourself _____ Additional listed on back (if necessary)

Are you or any family member presently receiving (Check all that apply and indicate the amount received monthly)?

- Cash Welfare Assistance? \$ _____ per month
- Food Stamps or other income support? \$ _____ per month
- Social Security Retirement Benefits \$ _____ per month
- Social Security or Private Disability \$ _____ per month
- Supplemental Security Income (SSI) \$ _____ per month
- VA Retirement Pension \$ _____ per month
- Death Benefits \$ _____ per month
- Alimony \$ _____ per month
- Child Support \$ _____ per month
- Rental Income \$ _____ per month
- Unemployment Insurance Benefits \$ _____ per month

CERTIFICATION:

I certify that the information provided in this application packet is true to the best of my knowledge. I understand this information is used to determine eligibility and I may be required to document the accuracy of this information. This information is subject to external verification and may be released for such purposes. If found ineligible after enrollment, I understand I will be terminated from the program. If I am terminated as a result of falsifying information on this application, I understand I may also be prosecuted for fraud. My signature serves as giving permission to verify any and all information contained in this application and the attached forms in the application packet. I acknowledge that I may be asked to provide follow-up information to assist in evaluation of this program.

Applicant Signature _____ Date ____/____/____

WORK HISTORY:

Are you currently employed? Yes ____ No ____ If yes, list employer, employment start date and wage.

_____ *Current employer* _____ *Start Date* _____ *Current Wage*

List all employers and work history below:

Employer _____ Job Title _____
 Address _____ Wage \$ _____
 City _____ State _____
 Start Date ____/____/____ End Date ____/____/____
 Reason for leaving _____
 Job Duties _____

Employer _____ Job Title _____
 Address _____ Wage \$ _____
 City _____ State _____
 Start Date ____/____/____ End Date ____/____/____
 Reason for leaving _____
 Job Duties _____

Employer _____ Job Title _____
 Address _____ Wage \$ _____
 City _____ State _____
 Start Date ____/____/____ End Date ____/____/____
 Reason for leaving _____
 Job Duties _____

REFERENCES

Work Related

Name _____ Address _____

City/State _____ Relationship _____ Phone # _____ - _____ - _____

Work Related

Name _____ Address _____

City/State _____ Relationship _____ Phone # _____ - _____ - _____

Personal Reference

Name _____ Address _____

City/State _____ Relationship _____ Phone # _____ - _____ - _____

Personal Reference

Name _____ Address _____

City/State _____ Relationship _____ Phone # _____ - _____ - _____

GOALS:

What steps do you think you need to take to increase your opportunities of getting a job, getting a better job, or keeping a job? _____

What is your long term employment goal? _____

Do you feel you have a need for additional training to achieve this goal? _____

How do you feel this program can help you? _____

Do you want to continue living in the same community you currently live in? Yes _____ No _____

If NO, where do you want to live? _____

Do you have any personal goals you wish to share? _____

SKILLS, INTERESTS & ABILITIES:

• List skills and abilities that you have used in school, your current or past employment. For example; Customer service, Construction skills, Office work, Auto mechanic, Management, etc. Also please list any all computer and technology skills you may have.

• Do you speak any languages other than English? YES _____ NO _____

What language? _____

• List any social memberships you have or volunteer work you do.

• Do you have any hobbies, if so please list them?

• What do you do in your spare time?

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Walk/jog, Exercise | <input type="checkbox"/> Talk with friends | <input type="checkbox"/> Make craft projects | <input type="checkbox"/> Yard Work |
| <input type="checkbox"/> Play video games | <input type="checkbox"/> Play Sports | <input type="checkbox"/> Auto Mechanics | <input type="checkbox"/> Cook/bake |
| <input type="checkbox"/> Read | <input type="checkbox"/> Wood Working | <input type="checkbox"/> Small engine repair | <input type="checkbox"/> Other _____ |

• If you desire to change employment do any of the following interest you?

- | | | | |
|---|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Office Work | <input type="checkbox"/> Truck Driving | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Maintenance | <input type="checkbox"/> Retail | <input type="checkbox"/> Cafeteria |
| <input type="checkbox"/> Working Outdoors | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | |

• **Do you prefer?**

- | | | |
|--|--|--|
| <input type="checkbox"/> I prefer to work with people | <input type="checkbox"/> I prefer to work by myself | <input type="checkbox"/> I prefer to work with the elderly |
| <input type="checkbox"/> I prefer to work with a group | <input type="checkbox"/> I prefer to work with children | <input type="checkbox"/> I prefer to work indoors |
| <input type="checkbox"/> I prefer to work outdoors | <input type="checkbox"/> I prefer to work with individuals with disabilities | |

CAP ADULT SERVICES PROGRAM

Agency Release of Information Form

I hereby authorize the release of information to or by Community Action Partnership of Northwest Montana (CAP) with the agencies listed below in order to determine eligibility and to provide complete and proper Case Management Services. I understand that the release will allow communication at needed intervals. I understand that this release will be updated as needed and may be revoked by me at any time with written notification. Also, I understand that I may cross out any agency that I do not wish CAP to share information with.

Applicants Name (Please Print)

Date

Signature

AGENCIES

- County Probation
- County Dept of Social Services
- County Dept of Health and Human Services/OPA
- County Law Enforcement Agencies
- Worksite Supervisor
- Office of Public Assistance
- WoRC Program Case Manager
- Other:
 - _____
 - _____
 - _____

Photo Release

I give permission for my photo to be taken at my work experience site, training site or in any other activities sponsored by CAP Agency as part of the Adult Employment Program. These photos may be published in the newspaper, posted or used in reports and publications of CAP.

Signature

Date

**COMMUNITY ACTION PARTNERSHIP of NORTHWEST MONTANA
EQUAL OPPORTUNITY IS THE LAW**

It is against the law for this recipient of Federal financial assistance to discriminate on the following basis:

Against any individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief; and

Against any beneficiary of programs financially assisted under Title IB of the Workforce Investment Act of 1998 (WIA), on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his or her participation in any WIA Title IB-financially assisted program or activity.

The recipient must not discriminate in any of the following areas:

- Deciding who will be admitted, or have access, to any WIA Title IB-financially assisted program or activity;
- Providing opportunities in, or 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.

WHAT TO DO IF YOU BELIEVE YOU HAVE EXPERIENCED DISCRIMINATION

If you think you have been subjected to discrimination under a WIA Title IB-financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:

The State WIA Title I Equal Opportunity Officer
Suzanne Ferguson, Montana Department of Labor and Industry
P. O. Box 1728, Helena, Montana 59624
e-mail address: sferguson@mt.gov
(406) 438-3552 / TDD/TTY (406) 444-0532
Fax: (406) 444-3037

OR YOU MAY CONTACT THE CIVIL RIGHTS CENTER BY WRITING

The Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210.

If you file your complaint with the state, you must wait either until a written Notice of Final Action is issued, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (see address above).

If you do not receive a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for that Notice before filing a complaint with CRC. 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 you receive 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 complaint with CRC within 30 days of the date on which you received the Notice of Final Action.

I have read and understand the above policy

Print Name of participant

Social Security Number

Signature of participant

Date

Alternate Format for Visual Impairment? Yes___ No___ N/A ___

DOLI is an Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities