YOUTH & LITERACY SERVICES APPLICATION



Please print your responses to the following questions and send via email to bossinfo@cobbworks.org. If you are unable to print, you can contact our offices at 770-528-4300 for options. Complete a separate form for each applicant.

Applicant Name	Social Security Numb	er		
First M.I. Last	-	-		
Birth Date (mm/dd/yy)	Age	Gende	r	
/ /		🗆 Mal	e □I	Female
Guardian/Other Contact Name	Guardian/Other Cont	tact Work I	Number:	
	() /fax ()			
Home Phone: Cell Phone	Email Address:			
Mailing Address:	City	State	Zip cod	e
Home Address	City	State	Zip cod	e
Someone with whom we can leave a message that does not live with you.	Living Situation:			
Name: Phone: Rent Own Hor		Homeless	🗆 Ten	nporary
Are you a US Citizen If you are not a US Citizen, please complete	2:			
□ Yes □ No Permanent Resident Card #:	Exp. Date	/ /		
Race (Check all that apply)				
🗆 White 🗆 Black 🗆 Asian 🗖 Pacific Islander 🛛 Native Americ	can 🗆 Hispanic 🛛	∃ Bi-racial/	other	
ELIGIBILITY INFORMATION				
Are you a Cobb County resident?		□ Y	ΈS	□ No
Do you have access to a laptop/tablet and internet		□ Y	ΈS	□ No
If NO, do you need help acquiring a laptop or internet?		t? □Y	ΈS	□ No
Do you have a disability or an Individual Education Plan (IEP)		Π Υ	ΈS	□ No
Does anyone in your household receive any of the following:				
SS Benefits Food Stamps TANF Medicaid Child	Support 🛛 Other	:		
Are you between the ages of 16-24? Please answer the following quest	tions:			
Are you behind one or more grade levels in school? (if applicable)		□ Y	ΈS	□ No
Do you have a misdemeanor or felony conviction?		ΠY	ΈS	□ No
Are you a high school dropout? Withdrawal Date:		□ Y	ΈS	□ No
Are you a runaway youth and/or homeless?		ΠY		□ No
Are you pregnant or parenting a child?		ΠY	ΈS	□ No
			ΈS	□ No

Do you need assistance in completing an educational program or securing and retaining a job?

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High Poverty Census Track:

% Below Poverty Level

□ YES

🗆 No

Staff Signature

Date

portunity Employer/Program	n I Auxiliary Aids & Ser	vices Available to Individua	als with Disabilities
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p	pportunity Employer/Progran		pportunity Employer/Program I Auxiliary Aids & Services Available to Individua PAGE 2

CERTIFICATION AND ACKNOWLEDGEMENT (Please read the following statement carefully)

I hereby affirm that the information provided on this application is true and complete to the best of my knowledge. I also agree that falsified information or significant omissions may disqualify me from further consideration for WIOA/CSBG program activities and may be considered justification for dismissal if discovered at a later date.

I further understand that if information presented is determined to be false or contain omissions, I will be held responsible for repayment of any funds paid to me or for services on my behalf.

Finally, I recognize that an application and eligibility determination are initial steps and do not guarantee program participation.

Applicant Signature

Parent/Guardian Signature (required if applicant is under 18 years of age)

Authorized Staff Signature (if applicable)

EDUCATION AND WORK HISTORY		
Highest grade level completed:		
School currently attending or last school attended:		
Anticipated date of HS graduation or GED attainment:		
Secondary education completed (if applicable): 🛛 High school diploma 🔲 G	GED	
Educational Goals:		
□ Fluency in English □ GED □ Technical Degree or Certification □ Ass	sociate's Degree	
□ Bachelor's Degree □ Master's Degree □ Improved Employment □ Oth	ner Graduate Degree	
Are you a veteran?	□ YES	🗆 No
I am a male registered with the Selective Service	□ YES	🗆 No
I am authorized to work in the United States	□ YES	🗆 No

Name of Employer		Type of E	Business
Address	City	State	Zip code
Dates Employed From (month/year - to (mor	nth/year)	Title	
Name and Title of Supervisor		Telephor	ne Number
		()	
May we Contact		Type of E	mployment
		🗖 Part	Time 🛛 Full Time
Brief description of duties:			
Reason for leaving:		Last Sala	nu:
			у.
		\$	Per

Date

Date

Date



Applicant Name: Social Security #:

To:

Income Period: From: (The income review period includes the last six months of paystubs)

(Application Date)

Family Composition: List each family member related by blood or marriage currently living in the home.

Family Member	Name	Relationship	Social Security #	Age	Copies of last 6 months of Income (as applicable)
1.		(self/applicant)			
2.					
3.					
4.					
5.					
6.					
7.					
8.					

	I attest that to the best of my knowledge the information above is true and correct.				
Certification:					
	Applicant Signature	Date			
	Parent/Guardian Signature	Date			

Family income calculations include the following:	Family income calculations exclude the following:
 Money, wages and salaries before any deductions (gross) 	Unemployment compensation
 Net receipts from nonfarm self-employment (receipts from a 	Child support payments
person's own unincorporated business, professional enterprise, or	Foster care payments
partnership, after deductions for business expenses)	 Public Assistance payments (TANF, SSI, RCA, GA)
 Net receipts from farm self-employment (receipts from a farm 	Old age and survivors insurance benefits
which one operates as owner, renter or sharecropper, after	• Financial assistance under Title IV of the Higher Education Act (i.e.
deductions for farm operating expenses)	Pell Grants, Federal Supplemental Educational Opportunity Grants,
 Social security disability income (SSDI) 	Federal Work Study)
 Regular payments from railroad retirement, strike benefits from 	Needs-based scholarship assistance
union funds, workers' compensation and training stipends	Income earned while a veteran was on active military duty and
Alimony	certain other veterans' benefits (see policy for exclusions)
Military family allotments or other regular support from an absent	Capital gains
family member or someone not living in the household	Any assets drawn down as withdrawals from a bank, the sale of a
 Pensions, whether private or government employee (including 	property, a house or a car
	 Tax refunds, gifts, loans, lump sum inheritances, one-time
	insurance payments or other compensation for injury
	• Noncash benefits such as employer-paid fringe benefits, food or
	housing received in lieu of wages, Medicare, Medicaid, food
Net gambling or lottery winnings	stamps, school meals and housing assistance
 Military family allotments or other regular support from an absent family member or someone not living in the household Pensions, whether private or government employee (including military retirement pay) Regular insurance or annuity payments College or university grants, fellowships and assistantships (see exclusion for needs-based scholarship assistance) 	 Capital gains Any assets drawn down as withdrawals from a bank, the sale of property, a house or a car Tax refunds, gifts, loans, lump sum inheritances, one-time insurance payments or other compensation for injury Noncash benefits such as employer-paid fringe benefits, food housing received in lieu of wages, Medicare, Medicaid, food

OFFICE USE ONLY				
Income Review:	Family Size:	Income Limit:	Total Six Months	of Income:
Staff Signature:			Eligible:	I YES I NO

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Equal Opportunity Employer/Program I Auxiliary Aids & Services Available to Individuals with Disabilities



SECTION I: Instructions to Employer

through WorkSource Cob Section II for the six (6) n	b. Please provide nonths immediate	the requested inform ely preceding the da	mation regarding employment	e eligibility for WIOA services provided and earnings for this individual listed in pleted, please fax this form to <u>1-888-</u> ssistance.
Name of Company:			Phone	·
Dates Employed:	Begin Date		End Date	
Pay Rate:	Amount	per _ I	Hour/Month/Year	
Gross Wages Earned During the preceding s	ix (6) months:	\$		to
Desition Title		Amount	Date	Date
Position Title:				
Employer Representati	ve Name		Employer Phone #	Date
SECTION II: Instruction	••	••	-	
you worked for differer	nt employers dur on to be used by	ing the past six (6 / the employer's rep) months, use a separate for presentative when completing	byed within the last six (6) months. If form for each. Complete the following ing this form.
Employee SS#:			DOB:	
Employee Signature:				^F Request:
	*The date	of the request should	be the same as the application de	ate.
SECTION III: Applicant	Authorization t	o Release Informa	tion (To be completed by a	pplicant)
information is necessa further authorize the st verbal or written inform my signature. I underst	ry to determine aff of WorkSour ation, if necess and all informat	eligibility for progra ce Cobb, its subco ary. This authoriza ion released to Wo	ams and/or services adminis ntractors, or authorized rep tion shall remain valid for rkSource Cobb will be confid	equested above. I understand this stered by WorkSource Cobb. I resentatives to obtain additional two (2) years from the date of dential and will not be released by ansmission is as valid as the
Applicant Name (Printe	ed)	S	ignature	
Applicant Social Securit	<mark>:y #</mark> :		Date of Birth	
Parent/Guardian Name (Required if Applicant is	not 18 years or ol		Date	Signed



. .

orkforce Developme		ontractors, and/or a \Box Obtain from	uthorized representatives of WorkSource Co
nstitution of Organi	zation Name		-
ddress			-
City	State	Zip Code	-
			y specific portion thereof)

my training under the Workforce Innovation and Opportunity Act (WIOA) from my past or future employers. I understand that this information is necessary for statistical and reporting purposes by WorkSource Cobb. All information I hereby authorize to be obtained by WorkSource Cobb will be held strictly confidential and cannot be released by WorkSource Cobb/CobbWorks without my written consent.

WIOA Customer Signature	Date	
Signature of Parent or Authorized Representative, where applicable	D <mark>ate</mark>	
WIOA Customer Name Printed	_	
Signature of Witness	Date	
Printed Name of Witness	_	
		WIOA - 101



The undersigned and his/her parent or legal guardian, if the participant is under the age of 18 years, do hereby execute this release, waiver and indemnification for himself/herself and his/her heirs, successors, representatives and assigns, and hereby agree and represent as follows:

The release of WorkSource Cobb/CobbWorks, Inc., its volunteers and officers, board members, employees and agents from any and all liability, loss, damage, costs, claims or causes of action including, but not limited to all bodily injuries and property damages arising out of the sole negligence of WorkSource Cobb/CobbWorks, Inc., and/or its affiliates.

I grant to WorkSource Cobb/CobbWorks, Inc. and its designated officers, employees, agents, or contractors the right to take photographs of me and my property in connection with the above-identified subject. I authorize WorkSource Cobb/CobbWorks, Inc. and its assigns and transferees to copyright, use and publish the same in print and/or electronically. I understand that WorkSource Cobb/CobbWorks, Inc. is a non-profit organization and will not generate profits from the use of my photograph. I understand my participation in being photographed is voluntary and I will not be compensated financially for my participation.

I agree that WorkSource Cobb/CobbWorks, Inc. may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I have read and understand the above:

Date	
Date	
State	Zip Code
	·
Printed Name	
UNLY	
	Date State Printed Name ONLY