



TO:

FROM:

Date:

Senior Participant:

Birthdate:

Social Security Number:

Host Agency:

\*\*\*\*\*  
HI HIRED: Start Date:

Supervisor

Pay Rate:

TERMINATED: Termination Date:

Reason for Termination:

\*\*\*\*\*  
TRANSFERRED: Effective Date:

Reason for Transfer:

\*\*\*\*\*  
SALARY CHANGE: Effective Date:

ADDRESS

TELEPHONE:

OTHER INFORMATION:

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Thank you very much for your cooperation. If you have any questions, you may call me at:

## ACTIVE Participant File Review Checklist

<b>Participant Name:</b>				<b>Date of Enrollment:</b>
<b>Approved Break:</b>				
File Review Element	Level of Compli.			
	Met	Not Met	N/A	
<b>Eligibility Documentation</b>				
Enrollment income calculation and documentation				
Family size verification				
Driver's License/ID				
Age verification				
Residence verification				

Table B reflects poverty limits used to determine whether an individual or family is at or below the poverty level for the District of Columbia and all states except Alaska and Hawaii as recorded on the SCSEP Participant Form, which is available in this manual's Appendix II or on the partners' page of the Center's website at <http://centerforworkforceinclusion.org>.

TABLE A: SCSEP Income Eligibility 125 Percent of Poverty		TABLE B: Poverty Levels 100 Percent of Poverty	
Number in Family	Annual Income Limits	Number in Family	100 Percent of Poverty
1	\$16,988	1	\$13,590
2	\$22,888	2	\$18,310
3	\$28,788	3	\$23,030
4	\$34,688	4	\$27,750
5	\$40,588	5	\$32,470
6	\$46,488	6	\$37,190
7	\$52,388	7	\$41,910
8	\$58,288	8	\$46,630
For families of more than eight, add \$5,900 for each additional member.		For families of more than eight, add \$4,720 for each additional member.	
Source: Office for the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health & Human Services. These limits are retroactive to January 12, 2022.			

Subgrantee No. \_\_\_\_\_

Participant's Name: \_\_\_\_\_

Income Worksheet / Page 1 of 2



Senior Community Service Employment Program

**Income Worksheet for (check one):**☐ **Participant**☐ **Other Family Member** (name): \_\_\_\_\_☐ **Spouse** (name): \_\_\_\_\_**Family Size:** \_\_\_\_\_**Type of Action** (Check one)

☐ Enrollment MM / DD / YYYY

☐ Recertification MM / DD / YYYY

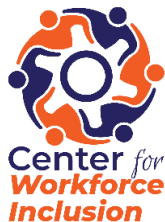
Includable Incomes & Documents used to verify	Month-Year	Month-Year	Month-Year	Month-Year	Month-Year	Month-Year	Months 1 through 6 Total
<b>Social Security Gross</b>							
Exclude 25% from Social Security Gross							
<b>Net (75% of Social Security Gross)</b>							
<b>Wages and Salary</b>							
<b>Self Employment Income</b>							
<b>Survivors Benefits</b>							
<b>Pension/Retirement Income</b>							
<b>Interest Income</b>							
<b>Dividends</b>							
<b>Rents/Royalties/Estates and Trusts</b>							
<b>Educational Assistance</b>							
<b>Alimony</b>							
<b>Financial Assistance from Outside the Household</b>							
<b>Other Includable Income</b>							

Months 1 through 6 Subtotal

Select the method of computing income ☐ 12 months or ☐ 6 months (if you use 6 months be sure to annualize in the Grand Total)

Case Notes: \_\_\_\_\_

Case notes required to document zero family income:



Senior Community Service Employment Program

**Income Worksheet for (check one):**☐ **Participant**☐ **Other Family Member** (name): \_\_\_\_\_☐ **Spouse** (name): \_\_\_\_\_**Family Size:** \_\_\_\_\_**Type of Action** (Check one)

☐ Enrollment MM / DD / YYYY

☐ Recertification MM / DD / YYYY

Includable Incomes & Documents used to verify	Month-Year	Month-Year	Month-Year	Month-Year	Month-Year	Month-Year	Months 7 through 12 Total
<b>Social Security Gross</b>							
Exclude 25% from Social Security Gross							
<b>Net (75% of Social Security Gross)</b>							
<b>Wages and Salary</b>							
<b>Self Employment Income</b>							
<b>Survivors Benefits</b>							
<b>Pension/Retirement Income</b>							
<b>Interest Income</b>							
<b>Dividends</b>							
<b>Rents/Royalties/Estates and Trusts</b>							
<b>Educational Assistance</b>							
<b>Alimony</b>							
<b>Financial Assistance from Outside the Household</b>							
<b>Other Includable Income</b>							
Based on the income eligibility guidelines, (Check only one): <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible (New: Participants found non-income-eligible at Recertification qualify as "Excludable." Please capture on Page 1 of Exit Form, #6. 1. ix.)						<b>Months 7 through 12 Subtotal</b>	
						<b>Months 1 through 12 Grand Total</b>	
<b>Signature Date:</b> ____ / ____ / ____ MM DD YYYY							
<b>Participant's Signature:</b> _____				<b>Project Staff Signature:</b> _____			
<b>Interviewer's Signature:</b> _____							
<b>Interviewer's Title:</b> _____							

## SCSEP Family Size Statement Form

[Participant self-attestation of family size is not allowed]

The purpose of this document is to assist the SCSEP applicant/participant with officially documenting family size when no other documentation is available.

I ( \_\_\_\_\_ ) swear and affirm that \_\_\_\_\_  
(Witness name) (Applicant/participant name)

is a member of a family of \_\_\_\_\_ (see the Center's Policy and Procedure Manual Section 204-B, for more  
(insert # in family size)  
information on the definition of family size).

I have no monetary interest in the determination of \_\_\_\_\_'s family size; further  
(Applicant/participant name)

\_\_\_\_\_ is not a member of my immediate family.  
(Applicant/participant name)

My relationship to the applicant/participant is: ☐ Landlord ☐ Apt. Manager ☐ Clergy ☐ Case/Social Worker  
☐ Neighbor ☐ Other, please specify: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### For Project Staff Use Only:

\_\_\_\_\_  
Signature of Project Staff

\_\_\_\_\_  
Date Received by Project



## PHOTO COPY DOCUMENTATION LISTED BELOW

THAT APPLIES

### ENROLLEE ONLY DOCUMENTATION:

Enrollee:

proof of Income, copy of driver's license and social security card

### ENROLLEE with ADDITIONAL FAMILY MEMBERS:

Enrollee/each additional Family member: proof of income, copy of driver's license and social security card for each member of the household

PROOF OF SOCIAL SECURITY INCOME MUST HAVE 2 PAGES ON THE AWARD LETTER:

THIS CAN BE AN ADDITIONAL 3+ DOCUMENTS



## Employee Direct Deposit Form

### Employee Instructions

1. Complete the employee required information section.
2. Complete the Direct Deposit section to specify where you want your paycheck deposited.
3. Complete the Account and Bank Information Section to specify which account you want your paycheck to be deposited.
4. Sign the bottom of the form. (Forms will not be processed without signatures.)
5. Return form to payroll. Payroll will provide you a copy.

### EMPLOYEE-Required Information

Please Print

Employee Name:

Social Security Number:

### Complete for DIRECT DEPOSIT

☐ I would like my wages/salary deposited to the bank account attached.

☐ Checking

☐ Savings

Bank Name:

Bank Name: .....

(Attach only a xqid check, bank letter, or specification sheet. No deposit tickets allowed.)

(Attach only a bank letter or specification sheet. No deposit tickets allowed.)

I wish to deposit (check one):

I wish to deposit (check one):

☐ Entire Net Pay

☐ Entire Net Pay

% of Net

% of Net

☐ Specific Dollar Amount \_\_\_\_\_

Specific Dollar Amount \_\_\_\_\_

### Complete ACCOUNT NUMBERS AND BANK INFORMATION FOR DIRECT DEPOSIT

Checking or Savings

Account#

Bank/Transit/ABA Routing Number

1)      or

2)      or

3)      or

4)      or

### AUTHORIZATION

I hereby authorize my employer, Caritas Family Solutions (hereinafter Agency) to deposit any amounts owed to me by initiating credit entries to my account at the financial institution (hereafter bank) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by AGENCY to my account. In the event that AGENCY deposits funds erroneously into my account, I authorize AGENCY to debit my account for an amount not to exceed the original amount of the erroneous credit. For my convenience, I request that PAYCOR directly deposit my wages/salary earned from my employer, into my bank account. I authorize PAYCOR to charge my account to recover funds erroneously credited to my account. I agree to hold PAYCOR harmless from loss and to indemnify it, limited to the amount of the deposit. Any dispute arising out of or in connection with this agreement, if not otherwise resolved, shall be determined by arbitration selected by AGENCY and in accordance with the Rules of the State of Illinois. This authorization is to remain in full force and effect until AGENCY and BANK have received written notice from me of its termination in such time and such manner as to afford AGENCY and BANK a reasonable opportunity to act on it.

### Employee Signature



### ACTIVE Participant File Review Checklist

<b>Participant Name:</b>	<b>Date of Enrollment:</b>		
<b>Approved Break:</b>			
	Met	Not Met	N/A
<b>Recertification Documentation</b>			
Recertification income calculation and documentation			
Recertification family size verification			

## ACTIVE Participant File Review Checklist

<b>Participant Name:</b>				<b>Date of Enrollment:</b>
<b>Approved Break:</b>				
	Met	Not Met	N/A	
<b>Program Documentation</b>				
Participant Form (PF)				
PF signed by staff and participant				
Orientation checklist signed by participant				
MIN appropriately identified/updated and documented				
CSA Description				
CSA Description training goals appropriate to individual and based on most recent Reassessment/IEP?				
CSA Form completed				
Release of information				
W-4 completed				
I-9 completed				
Annual physical exam offer/waiver				
Approved Breaks in Service correctly documented				
Grievance records				
No medical records in participant file				

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the Center's Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

### Participant Information

1. Last name: \_\_\_\_\_
2. First name: \_\_\_\_\_
3. Middle initial: \_\_\_\_\_
4. Social Security #: \_\_\_\_\_
- 4a. Participant ID: \_\_\_\_\_  
Participant ID Number assigned by SPARQ
5. Home phone: \_\_\_\_\_  
If participant only has a cell phone, please insert Here as Home Number.
- 5a. Cell phone: \_\_\_\_\_
6. Mailing address:  
\_\_\_\_\_  
a. Number and Street, Apt. Number; or PO Box  
\_\_\_\_\_  
b. City \_\_\_\_\_ c. State ♦ \_\_\_\_\_  
\_\_\_\_\_  
d. ZIP Code \_\_\_\_\_ e. County \_\_\_\_\_
- 6a. Participant's e-mail address: \_\_\_\_\_
- 6b. Emergency contact: Name \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship \_\_\_\_\_
7. State of residence if different from mailing address \_\_\_\_\_

#### 6c. ♦DV TIP

Document used to verify (drivers' license, Governmental ID card, official government mail dated within last 30 days, bank statement, other)

#### Authorized for Local Reproduction

ETA-9120

(Revised November 2018; replaces prior versions)

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average twelve (12) minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Adult Services, Room S-4203, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Participant Form

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8. Homeless♦ (MIN) ☐ Yes♦ ☐ No

### 8. ♦Definition & DV TIP

An individual who lacks a fixed, regular and adequate night-time residence or who has a primary night time residence that is either a supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters and transitional housing for the mentally ill) or a temporary residence for individuals intended to be institutionalized, or a public or private place not designed or ordinarily used as regular sleeping accommodation for people. Document used to verify (self-attest form).

8a. Urban/rural ☐ Urban ☐ Rural (MIN)♦

### 8a. ♦Definition & DV TIP

No documentation needed. Auto validated.

9. Application date for enrollment or re-enrollment \_\_\_\_\_ (MM/DD/YYYY)

## Eligibility Information

10. Date of birth:♦ \_\_\_\_\_ (MM/DD/YYYY)

### 10. ♦DV TIP

Document used to verify (Driver's license, birth certificate, DD-214, marriage license or divorce decree, passport, Social Security Award letter, work permit, other)

11. Number in family: \_\_\_\_\_ ♦

### 11. ♦DV TIP

Document used to verify (family size form, official government records such as: a lease or HUD form, other)

12. Receiving public assistance? (Check as many as apply)

☐ a. No

☐ c. TANF

☐ e. Suppl. Nutrition Assistance (SNAP)

☐ g. Social Security Disability (SSDI)

☐ b. Supplemental Security Income (SSI)

☐ d. State or local welfare (General Assistance)

☐ f. Subsidized housing

☐ h. Other (specify): \_\_\_\_\_

Participant Name \_\_\_\_\_  
Last First Middle

# SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

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13. Employed prior to participation?

- ☐ i. Employed    ☐ ii. Employed, but with notice of termination    ☐ **iii. Not employed ♦**

## 13iii ♦Definition & DV TIP

An individual employed on the date of participation is one who, on the date participation occurs:

- Did any work at all as a paid employee (except the individual is NOT considered employed if: a) he/she has received a notice of termination of employment or the employer has issued a Worker Adjustment and Retraining Notification (WARN) or other notice that the facility or enterprise will close; or b) he/she is currently on active military duty and has been provided with a firm date of separation from military service);
  - Did any work at all in his/her own business, profession, or farm;
  - Worked 15 hours or more as an unpaid worker in an enterprise operated by a member of the family; or
  - Was not working, but has a job or business from which he/she was temporarily absent because of illness, bad weather, vacation, labor-management dispute, or personal reasons, whether or not paid by the employer for time off, and whether or not seeking another job.
- ☐ Enter ii if the participant is a person who, although employed, has received notice of termination of employment.  
☐ Enter iii if the individual does not meet the definitions listed above, i.e., was not employed on the date of participation.  
☐ Since SCSEP participants are required to be unemployed at the point of enrollment, only those for whom you have recorded a iii are eligible to become participants.

Document used to verify (self or 3<sup>rd</sup> party attest form, government or business records, detailed case notes or other).

14. **Total includable family income: ♦** 12-month or 6-month annualized (6 months x 2)

\$\_\_\_\_\_ ♦ (This number must match the amount on your income worksheet.)

**14 ♦DV TIP** Documents used to verify (For zero income, self or 3<sup>rd</sup> party attest form documenting how participant supports himself. For income amounts, official documents and business records that establish includable income such as pay stubs, Social Security Award letters, pension statements, bank statements showing interest, earning statements from employers, other).

Participant Name \_\_\_\_\_  
Last First Middle

**SCSEP SELF-ATTESTATION FORM**  
**FOR ITEM P13 —**  
**EMPLOYED PRIOR TO PARTICIPATION?**

On this date, I, \_\_\_\_\_, certify  
(NAME OF APPLICANT/PARTICIPANT)

I am not employed, that is:

- ☐ I do not do any work at all as a paid employee; **and**
- ☐ I do not do any work at all in my own business, profession, or farm; **and**
- ☐ I do not work 15 hours or more as an unpaid worker in an enterprise operated by a member of my family; **and**
- ☐ I do not have a job or business from which I was temporarily absent because of illness, bad weather, vacation, labor-management dispute, or personal reasons.

\_\_\_\_\_  
Applicant's/Participant's Signature

\_\_\_\_\_  
Date



## SCSEP Self-Attestation Form for Item P14

On this date, I \_\_\_\_\_ (Name of Applicant),

☐ twelve months

I have supported myself during this period of time as follows:

[illegible]

Signature of Applicant

## SCSEP Participant Form

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You must secure acceptable validation documentation.  
See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

- 
15. Family income at or below 100% of poverty level? ☐ Yes ☐ No
16. Formerly a participant in any SCSEP project? ☐ Yes ☐ No
17. \*Transferred from another project? ☐ Yes ☐ No  
If yes, specify prior grantee code: \_\_\_\_\_  
Date of transfer: \_\_\_\_\_
- 17a. \*Change of sub-grantee? ☐ Yes ☐ No  
If yes, specify prior sub-grantee code: \_\_\_\_\_  
Date of change: \_\_\_\_\_

## Other Personal Characteristics and Information

18. **Gender** ☐ Male ☐ Female ☐ Did not voluntarily report
19. **Ethnicity**: Hispanic, Latino, or Spanish origin?  
☐ Yes ☐ No ☐ Did not voluntarily report
20. **Race** (Check as many as apply)  
☐ a. American Indian or Alaskan Native ☐ b. Asian  
☐ c. Black, African American ☐ d. Native Hawaiian/Pacific Islander  
☐ e. White ☐ f. Did not voluntarily report

21. **Education** \_\_\_\_\_ last grade completed (Select one code from following list)

00= no grade school  
1-11 years of school  
A11=completed 12 years  
of school but no HS  
diploma  
12 = HS diploma

88=GED or certificate of equivalency for HS  
13-15 years of school completed (1-3 years of college)  
16=BA/BS or equivalent  
17=education beyond a bachelor's degree

18=master's degree  
19=doctoral degree  
21=vocational/technical degree  
22=associate's degree

\* No data entry in SPARQ. Field is system-generated

Participant Name \_\_\_\_\_  
**Last** **First** **Middle**



## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

22. **Limited English Proficiency (LEP)** ♦ ☐ Yes (MIN) ☐ No  
You can check "yes" only for those who speak a language other than English as their primary language.

**22. ♦DV TIP**

Document used to verify (self-attest form, standardized or literacy test results, detailed case notes, other)

23. If LEP, please specify primary language \_\_\_\_\_ (Select one code from following list)

- |                     |                  |                              |                  |
|---------------------|------------------|------------------------------|------------------|
| 10. Amharic         | 20. Hebrew       | 30. Mon-Khmer (Cambodian)    | 40. Spanish      |
| 11. Arabic          | 21. Hindi        | 31. Navajo                   | 41. Tagalog      |
| 12. Armenian        | 22. Miao (Hmong) | 32. Persian (including Dari) | 42. Thai         |
| 13. Bosnian         | 23. Italian      | 33. Polish                   | 43. Urdu         |
| 14. Cantonese (Yue) | 24. Hungarian    | 34. Portuguese               | 44. Vietnamese   |
| 15. French          | 25. Ilocano      | 35. Punjabi                  | 45. Yiddish      |
| 16. French Creole   | 26. Japanese     | 36. Russian                  | 46. Other: _____ |
| 17. German          | 27. Korean       | 37. Samoan                   |                  |
| 18. Greek           | 28. Laotian      | 38. Serbo-Croatian           |                  |
| 19. Gujarathi       | 29. Mandarin     | 39. Somali                   |                  |

24. **Low literacy skills?** ☐ Yes♦(MIN) ☐ No  
You can check "yes" only for those who speak English as their primary language.

**24. ♦DV TIP**

Document used to verify (self-attest form, standardized or literacy test results, detailed case notes, other)

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

25. **Veteran** (or eligible spouse of veteran)? ☐ a. Veteran ♦(MIN)

### 25. ♦Definition & DV TIP

A person who served in the active military, navy or air force who was not dishonorably discharged or released. Active service includes full-time duty in the National Guard or a Reserve component, other than full-time duty for training purposes.

Document used to verify (self-attest form, military discharge papers (DD-214), detailed case notes.

☐ b. Eligible spouse of veteran♦(MIN)

☐ c. Non-covered person

### 25. b ♦Definition & DV TIP

Someone who is married to a veteran who has a service-related total disability or died of one, is a member of the Armed Forces on active duty who has been listed for a total of more than 90 days as missing in action, captured in line of duty by a hostile force or forcibly detained or interned by a foreign government or power.

Document used to verify (self-attest form, military discharge papers (DD-214), detailed case notes.

If veteran, post-9/11 era veteran? ☐ Yes♦ ☐ No ♦

### ♦Definition & DV TIP

Post 9/11 Era Veterans are veterans who served in active military service on or after September 11, 2001, regardless of the length of service, excluding those who were discharged for other than honorable conditions.

Document used to verify (self-attest form, military discharge papers (DD-214), detailed case notes.

26. **Disability?**

☐ Yes, self-report

☐ Yes, documentation\* ♦ (MIN)

☐ No

☐ Did not voluntarily report

### 26. ♦DV TIP

If an applicant is claiming disability for purposes of income eligibility (for a family of one), documentation is required. Acceptable documentation would include proof of a government disability determination. If no such formal determination has been made, you may accept a doctor's certification. If the applicant is not claiming disability for eligibility purposes, then disability is an equal opportunity (EO) item, and disclosure is voluntary. In that case, documentation is not required; however, without documentation, you will not receive credit in the most-in-need measure.

27. **At risk of homelessness?**

☐ Yes ♦(MIN) ☐ No

### 27. ♦Definition and DV TIP

An individual who is likely to become homeless and lacks the resources and support networks needed to obtain housing.

Documents used to verify (self-attestation form, eviction notice, detailed case notes, other).

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

28. Displaced homemaker? ☐ Yes ☐ No

29. Failed to find employment after using WIA Title I? ☐ Yes♦ (MIN) ☐ No

### 29. ♦Definition and DV TIP

You must determine if the participant was officially enrolled in WIA to answer "yes" to this question. Check "yes" if the participant has a WIA case manager.

Document used to verify (self-attest form, WIA correspondence with participant, other WIA program document or detail case notes).

30. Low employment prospects? ☐ Yes♦ (MIN) ☐ No

### 30. ♦Definition and DV TIP

To check "yes," the participant must have one or more documented significant barriers to employment. The validation documentation must explain how the barrier(s) results in the participant having low employment prospects.

Document used to verify barriers (self-attest form, SSDI records, standardized or literacy test results, letter from shelter director, medical records, other)

31. Personal characteristics comments

Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

Name or initials of person making note: \_\_\_\_\_

Date the information was obtained: \_\_\_\_\_

Detailed Case Notes: \_\_\_\_\_

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
 See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

### Certification

*I hereby certify that the above information is true and accurate to the best of my knowledge and belief.  
 I understand that if I intentionally provide inaccurate information, I may be terminated from the SCSEP  
 program and may be subject to legal penalties.*

32. Signature of applicant: ♦ \_\_\_\_\_

**32. ♦DV TIP**

Signature must be obtained.

33. Date of signing: ♦ \_\_\_\_\_ (MM/DD/YYYY)

**33. ♦DV TIP**

This date must match what you input into SPARQ for this field.



### Eligibility Determination

34. ☐ Eligible ☐ Ineligible

35. If ineligible, reason (Check as many as apply)

☐ a. Age ☐ b. Income ☐ c. Residence outside of state

☐ d. Failed to complete application or provide required documentation

☐ e. Other (specify): \_\_\_\_\_

36. If ineligible, action taken (Check as many as apply)

☐ a. Referred to One-Stop

☐ b. Referred to social services

☐ c. Referred to another project

☐ d. Placed in unsubsidized employment pursuant to MOU

☐ e. Other (specify): \_\_\_\_\_

Participant Name \_\_\_\_\_  
                                     Last                                    First                                    Middle

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

### Enrollment Information

37. Placed on waiting list? ☐ Yes ☐ No
38. Community service assignment? ☐ Yes ☐ No
39. Grantee name: \_\_\_\_\_
- 39a. County of authorized position: \_\_\_\_\_
40. Co-enrollments? (Check as many as apply)
- ☐ a. WIA ☐ b. Employment Service ☐ c. Adult Education
- ☐ d. College/Community College
- ☐ e. Other (specify): \_\_\_\_\_
- ☐ f. None
- 40a. Date of orientation: \_\_\_\_\_ (MM/DD/YYYY)
- 40b. Date of last physical or waiver: \_\_\_\_\_ (MM/DD/YYYY)
- 40c. Date of last IEP: \_\_\_\_\_ (MM/DD/YYYY)

#### 40c. ♦DV TIP

Official subgrantee record, the last Reassessment, the last Transitional Assessment, the last Individual Employment Plan or the Initial Assessment if that is the recent activity; and the date on which they were conducted.

- 40d. Job interest codes: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> 1. Art, Design, Entertainment, Sports, and Media | <input type="checkbox"/> 8. Food Preparation and Service       | <input type="checkbox"/> 15. Production, Assembly, Light Industrial |
| <input type="checkbox"/> 2. Business and Financial Operations             | <input type="checkbox"/> 9. Healthcare                         | <input type="checkbox"/> 16. Protective Service                     |
| <input type="checkbox"/> 3. Community and Social Services                 | <input type="checkbox"/> 10. Legal                             | <input type="checkbox"/> 17. Retail, Sales, and Related             |
| <input type="checkbox"/> 4. Computer and Mathematical                     | <input type="checkbox"/> 11. Maintenance and Custodial         | <input type="checkbox"/> 18. Self-Employment                        |
| <input type="checkbox"/> 5. Construction, Installation, and Repair        | <input type="checkbox"/> 12. Management                        | <input type="checkbox"/> 19. Transportation and Material Moving     |
| <input type="checkbox"/> 6. Education, Training, and Library              | <input type="checkbox"/> 13. Office and Administrative Support |   |
| <input type="checkbox"/> 7. Farming, Fishing, and Forestry                | <input type="checkbox"/> 14. Personal Care and Service         |   |

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

### 41. Enrollment comments

Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

Name or initials of person making note: \_\_\_\_\_

Date the information was obtained: \_\_\_\_\_

Detailed Case Notes: \_\_\_\_\_

### 42. Signature of project director or authorized representative ♦

\_\_\_\_\_  
Signature line

#### 42. ♦DV TIP

Must be signed by staff authorized to make final eligibility.

### 43. Date of eligibility determination ♦ \_\_\_\_\_ (MM/DD/YYYY) ♦

#### 43. ♦DV TIP

This date must match what you input into SPARQ for this field.

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

### Recertification

(You will complete this section during the Center's annual Recertification Process) **in August**

44. Number in family: \_\_\_\_\_ ♦

**44. ♦DV TIP**

Document used to verify (family size form, official government records such as: a lease or HUD form, other case notes, self-attest only for veterans discharged prior to 1950).

45. Total includable family income [12-month or 6-month annualized (6 months x 2)]: \$ \_\_\_\_\_ ♦

**45. ♦DV TIP**

Documents used to verify (For zero income, self or 3<sup>rd</sup> party attest form. For income amounts, official documents and business records that establish includable income such as pay stubs, Social Security Award letters, pension statements, bank statements showing interest, earning statements from employers, other).

### Certification

*I hereby certify that the above information is true and accurate to the best of my knowledge and belief. I understand that if I intentionally provide inaccurate information, I may be terminated from the SCSEP program and may be subject to legal penalties.*

46. Signature of participant on recertification: \_\_\_\_\_

47. ☐ Eligible ☐ Ineligible

48. If ineligible, reason (Check as many as apply)

- ☐ a. Income ☐ b. Failed to complete application or provide required documentation  
☐ c. Other (specify) \_\_\_\_\_

49. Signature of director or authorized representative on recertification

\_\_\_\_\_

**49. ♦ DV TIP**

Must be signed by staff authorized to make final eligibility determination.

50. Date of recertification determination \_\_\_\_\_ (MM/DD/YYYY) ♦

**50. ♦ DV TIP**

This date must match what you input into SPARQ for this field.

Participant Name \_\_\_\_\_ Page 11  
Last First Middle

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

### Most In Need

(Capture any of these MIN factors at initial enrollment; you will follow the Center's process for any updates to these factors for MIN characteristics). Note: In SPARQ fields, you will see "Waiver of Durational Limit"

51. **Severe disability?♦** ☐ Yes (MIN) ☐ No

51a. Date of last update \_\_\_\_\_ (MM/DD/YYYY)

**Definition & DV TIP:** a severe, chronic disability attributable to mental or physical impairment(s), or a combination of mental and physical impairments, that: (1) is likely to continue indefinitely and (2) results in substantial functional limitation in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and/or economic self-sufficiency.

Acceptable documentation includes the following: the Center's Severe Disability form; when a medical certification or statement is used to support, related documentation should be an official government record or other official record that: (1) Indicates that a medical professional made a determination of disability; and (2) Describes how the disability meets the regulatory definition (as stated in the Policy and Procedure Manual), including but not limited to: Social Security Administration records; school records; sheltered workshop certification; social service records or referrals; community-based aging and disability organization records; Independent Living Center records; letter from a group home administrator; referral from Vocational Rehabilitation. Receipt of Social Security Disability Insurance (SSDI) is NOT sufficient to verify "severe disability". Certifications or statements from medical professionals must not merely conclude that a severe disability exists. They must clearly establish the facts that meet the regulatory definition of "severe disability."

52. **Frail?♦** ☐ Yes (MIN) ☐ No

52a. Date of last update \_\_\_\_\_ (MM/DD/YYYY)

**Definition & DV TIP:** an individual 55 years of age or older determined to be functionally impaired because the person is (1i) not able to perform at least two (2) activities of daily living without substantial human assistance, including verbal reminding, physical cueing or supervision; or (1ii) at the option of the project director, is unable to perform at least three (3) such activities without such assistance; (2) or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to him or herself or to another individual.

Acceptable documentation of "frail" includes the following: the Center's Frail form; when a medical certification or statement is used to support, related documentation should be an official government record or other official record that (1) Indicates that a qualified professional made a determination of frailty; and (2) describes how the disability meets the regulatory definition (as stated in the Policy and Procedure Manual), including but not limited to: Medical records, certification from a qualified professional; physician's evaluation; disability records; Veteran's medical records; vocational statement; psychologist's diagnosis; rehabilitation letter; worker's compensation record. When a specific professional certification or statement is NOT used as support, official government or other official records may still be used as long as they establish how the frailty meets the regulatory definition, including but not limited to: Social Security Administration records; school records; sheltered workshop certification; social service records, document from a rehabilitation agency/organization to include a recent evaluation; social service agency record or referral; community-based aging and disability organizations; Independent Living Center statement; letter from a group home administrator. Receipt of Social Security Disability Insurance (SSDI) is NOT sufficient to verify "frail".

Participant Name \_\_\_\_\_ Page 12

**Last** **First** **Middle**



## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

53. **Old enough for but not receiving SS Title II?♦** ☐ Yes (MIN) ☐ No

53a. Date of last update \_\_\_\_\_ (MM/DD/YYYY)

**Definition & DV TIP:** a person may qualify for Social Security retirement benefits at age 62; however if the person is 62 or older and does not have sufficient wage credits to qualify for Social Security Retirement, then the person would qualify for this waiver factor.

Acceptable documentation includes: official government document that establishes that the participant has not worked in the U.S. for 40 quarters, including but not limited to: Social Security Administration documents (e.g. Social Security Statement) or immigration records that show the participant has not been in the U.S. for 40 quarters (10 years).

54. **Severely limited employment prospects in area of persistent unemployment?♦** ☐ Yes (MIN) ☐ No

54a. Date of last update \_\_\_\_\_ (MM/DD/YYYY)

**Definition & DV TIP:** Severely limited employment prospects in an area of persistent unemployment is a waiver factor that has two (2) separate requirements both of which must be met in order for someone to qualify. The two requirements are (1) severely limited employment prospects AND (2) reside in an area of persistent unemployment.

Part 1: Severely limited employment prospects means the substantial likelihood that an individual will not obtain employment without the assistance of SCSEP or another workforce development program. Persons with severely limited employment prospects have two or more documented significant barriers to employment; significant barriers to employment may include but are not limited to: lacking a substantial employment history, basic skills, and/or English-language proficiency; lacking a high school diploma or the equivalent; having a disability; being homeless; or residing in socially and economically isolated rural or urban areas where employment opportunities are limited.

Acceptable documentation for this part of the definition includes: self-attest form; or detailed case notes and notations on your initial assessment form; or official records that establish that two or more significant barrier to employment exists such as certification from a medical professional, actual medical record (see documentation requirements for Frail, Disabled, and Severely Disabled).

Part 2: Reside in an area of persistent unemployment means a person who lives in an area where the annual average unemployment rate for a county or city is more than 20% higher than the national average for two out of the last three years.

Acceptable documentation for part 2 of the definition is found on the county look-up table.

55. **Limited English Proficiency (LEP)?♦** ☐ Yes (MIN) ☐ No

55a. Date of last update \_\_\_\_\_ (MM/DD/YYYY)

**Definition & DV TIP:** means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English. Note: for SCSEP purposes, a participant cannot be LEP and have low literacy skills as the designation of "low literacy skills" only applies to individuals who speak English as their first language.

Acceptable documentation includes: self-attest form; or third party attestation form; or detailed case notes and notations on your initial assessment form or official records that establish limited English proficiency are acceptable, including but not limited to: results of literacy testing, standardized test results.

Participant Name \_\_\_\_\_ Page 13

**Last** **First** **Middle**

## SCSEP Participant Form

Fields marked with ♦ indicate a data validation field.

MIN = Most in Need Factor

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

56. **Low literacy skills?♦** ☐ Yes (MIN) ☐ No

56a. Date of last update \_\_\_\_\_ (MM/DD/YYYY)

**Definition & DV TIP:** means the individual computes or solves problems, reads, writes, or speaks at or below the 8<sup>th</sup> grade level or is unable to compute or solve problems, read, write, or speak at a level necessary to function on the job, in the individual's family, or in society. **Note:** for SCSEP purposes, a participant cannot have low literacy skills and have the designation LEP, as the designation "low literacy skills" refers only to individuals who speak English as their first language.

Acceptable documentation includes: self-attest form; or third party attestation form; or detailed case notes and notations on your initial assessment form or official records that establish low literacy skills are acceptable, including but not limited to: results of literacy testing, standardized test results.

\*57. **75 or over?♦** ☐ Yes (MIN) ☐ No

**Definition & DV TIP:** Age 75 or older before reaching four-year/48-month participation cap. Acceptable Documentation includes but is not limited to: Driver's License, Federal, State or Local Government ID, Government or other official document with your birth date listed (month/day/year), Birth certificate.

**\* No data entry in SPARQ. Field is system-generated.**

58. Recertification/waiver comments

Name of source of the information: \_\_\_\_\_  
His/her phone number: \_\_\_\_\_  
His/her organization and title or relationship to participant: \_\_\_\_\_  
Name or initials of person making note: \_\_\_\_\_  
Date the information was obtained: \_\_\_\_\_  
Detailed Case Notes: \_\_\_\_\_

## Record of Participant Orientation

My signature here is acknowledgment that I have had fully explained to my satisfaction the following matters concerning my enrollment as a participant in the SCSEP:

	Goals of SCSEP
	Goals of the sponsor organization and the Center for Workforce Inclusion
	Available supportive services
	Physical exam offer
	Training opportunities
	SCSEP participant meetings
	Obligation to seek unsubsidized employment, including applying for jobs at host agency and registering with the One-Stop Career Center
	Post enrollment and unsubsidized information to be collected (Release Form to be given to participant)
	Community Service Assignment Description
	DOL mandated Participant Customer Satisfaction surveys
	Privacy Act of 1974 (copy of Statement to be given to the participant)
	Hours of community service
	Wage rate / required benefits
	Submission of timesheets, schedule and method of payment of wages
	Procedures for complaint resolution
	Procedures for reporting assignment-related accidents
	Travel reimbursement, if applicable
	Durational limit on SCSEP participation
	Rotation policy for community service assignment
	Obligation to report any change in income or family size that may affect eligibility
	Drug-free work place policy
	Reasons for termination (including IEP termination)
	Allowable and unallowable political activities

Further, I have been given a copy of the sponsor's SCSEP participant policies and a copy of my community service assignment description.

(Signature of Participant)

(Date)

Please record this Orientation on the "Participant Information Tool".

I have received a copy of the Center for Workforce Inclusion / Caritas Family Solutions Senior Community Service Employment Program (SCSEP) Participant & Host Agency Handbook that includes information on:

- What is the Caritas Family Solutions SCSEP
- Participant's Responsibilities
- Program Services
- Training Assignments
- Safety and Accident Reporting
- Payroll and Timesheets
- Policy
  - Drugs and weapons in the Workplace
  - Approved Break
  - Durational Limits
  - Involuntary Termination Policy
  - Non-Discrimination & Grievance Policy & Procedures
- Holiday Policy
- Political Activity
- Federal Regulations

In addition, I understand the Program Manager is available to discuss any questions or concerns that may come up in the future.

Gary D. Woods, Program Manager

Office Phone: (618) 688-1180

Direct Phone: (618) 688-1127

---

Participant Signature

Date

---

Project Manager Signature

Date

## SCSEP PROGRAM REQUIREMENTS CHECKLIST

The purpose of the SCSEP is to provide part-time training while I actively seek unsubsidized employment in order to graduate from the program. SCSEP is not a permanent job. This program does not have the funding to serve everyone who is eligible, and this program does not have the ability to serve those with no reliable transportation or those who do not wish to find a job off the program. \_\_\_\_\_ (initials)

If I am determined eligible and enroll, and/or when I get a job off the program, I understand that I may lose all or part of those public benefits I now receive. These benefits may include: Public Housing, Food Stamps (SNAP), TANF, SSI/SSDI, Medicaid, and Unemployment. \_\_\_\_\_ (initials)

1. I acknowledge that if I am found eligible and enroll and/or when I find unsubsidized employment that I may lose all or part of the benefits noted above. \_\_\_\_\_ (initials)
2. I agree—even if I may lose benefits—that if I am enrolled I will cooperate with the Program Manager/Project Office Staff by:
  - Accepting referrals and interviews for unsubsidized jobs. \_\_\_\_\_ (initials)
  - Conducting an ongoing search for unsubsidized employment as specified in my IEP and as directed by the Program Manager/Project Office Staff. \_\_\_\_\_ (initials)
  - Accepting regular transfers of my host agency assignments as necessary to further my training and work experience. \_\_\_\_\_ (initials)
  - Maintaining registration with the One Stop Employment Service Center. \_\_\_\_\_ (initials)
  - Attending job search training, participant meetings, etc. when required by the Project Office, and to engage in continuing unsubsidized job search activities. \_\_\_\_\_ (initials)
3. SCSEP is a short-term, work-training program usually lasting months, not years, which helps to prepare participants for unsubsidized employment. SCSEP participants are considered to be in temporary, training status, preparing to accept unsubsidized employment off of the program. The program is not an entitlement, nor is it designed to provide income maintenance. I acknowledge that training with the Host Agency is NOT a job, and if I am enrolled, I am not an employee of either Caritas Family Solutions or the Host Agency to which I am assigned. \_\_\_\_\_ (initials)
4. SCSEP is a federally grant funded, Department of Labor (DOL) work-training program; to which, participants do not pay into unemployment. Therefore, when leaving the program, participants are not eligible for unemployment benefits. \_\_\_\_\_ (initials)
5. I may not volunteer time at my Training Assignment, and I will not be paid for any time that was not authorized or that was performed outside of my work-training schedule. In addition, the Training Provider (Host Agency) may request my removal anytime my behavior, attendance, attitude, or aptitude proves detrimental to the agency or SCSEP. \_\_\_\_\_ (initials)

## **SCSEP PROGRAM REQUIREMENTS CHECKLIST**

6. The Program Manager may change my enrollment status or terminate my work training Host Agency assignment at any time. Participants complete a skills assessment and an *Individual Employment Plan (IEP)* upon enrollment. Based on the needs of Caritas Family Solutions SCSEP, I could be transferred from one work-training assignment to another to broaden my experience and better prepare me for an unsubsidized job off of this program or to make adjustments to the program as required by funding. The number of transfers, length of training assignments, and the location of my assignment are based on my status and progress in the program AND the needs of the program for ongoing support. I should not compare my progress, transfers, and tenure on the program with anyone else. \_\_\_\_\_ (initials)
7. Caritas Family Solutions SCSEP reserves the right to set participant training hours based on the budget available and other program considerations in the county where the participant is assigned. This may result in cases where less than 20 hours per week is available. \_\_\_\_\_ (initials)
8. Do you own a vehicle? If yes, my initials attest to having both a valid driver's license and valid auto insurance. If no, please indicate with N/A. \_\_\_\_\_ (initials)
9. At the time of participation, I am not employed, ie.:
- I do not do any work at all as a paid employee. \_\_\_\_\_ (initials)
  - I do not do any work at all in my own business, profession, or farm. \_\_\_\_\_ (initials)
  - I do not do any work 15 hours or more as an unpaid worker in an enterprise operated by a member of my family. \_\_\_\_\_ (initials)
  - I do not have a job or business from which I was temporarily absent because of illness, bad weather, vacation, labor-management dispute, or personal reasons. \_\_\_\_\_ (initials)
10. Caritas Family Solutions SCSEP may change participant benefits and guidelines at any time, and reduce my hours if necessary due to budgetary constraints. \_\_\_\_\_ (initials)
11. My enrollment in the SCSEP is based on a number of things, including my continuing eligibility, satisfactory performance of my work-training assignments; suitable transportation that allows me to accept training and an unsubsidized job at locations throughout my community; and my willingness to actively cooperate in the job search process as spelled out in my IEP and directed by the Program Manager and/or Project Office Staff. If information I provided to meet the programs' eligibility is inaccurate, I may be subject to immediate dismissal. \_\_\_\_\_ (initials)
12. I understand that enrollment in the SCSEP is normally months, not years. Under most circumstances a participant will have taken advantage of all the resources and services in this program after two or three training assignments and should be well on his/her way to finding unsubsidized employment off the program. Given Caritas Family Solutions SCSEP's limited funding and the number of eligible individuals who need our help, Caritas Family Solutions SCSEP cannot keep individuals on the program who have exhausted all resources. \_\_\_\_\_ (initials)

## SCSEP PROGRAM REQUIREMENTS CHECKLIST

13. While not a condition of enrollment, it is expected that participants will maintain a bank account and utilize the program's direct deposit service. \_\_\_\_\_ (initials)
14. I agree to provide Caritas Family Solutions SCSEP all my employment information, once I have secured an unsubsidized job, no matter how the job was obtained. \_\_\_\_\_ (initials)
15. I agree to allow the release of information about my enrollment, assignments, employment status and wages while enrolled or for up to a year after leaving the program for reporting or program promotion purposes. \_\_\_\_\_ (initials)
16. I grant Caritas Family Solutions SCSEP permission to video tape and take photographs of (Print Participant Name) \_\_\_\_\_ and to use said photos on Caritas Family Solutions SCSEP's website, facebook page, and other social media and news media outlets as part of promoting Caritas Family Solutions SCSEP. \_\_\_\_\_ (initials)
17. I understand that as part of my enrollment I may be asked to complete a Customer Satisfaction Survey. I agree I will complete this survey and submit it in a timely manner if asked. \_\_\_\_\_ (initials)
18. As part of my enrollment, I may be asked/directed to attend meetings, conduct job searches or come into the Project Office. Because of our limited resources, the Project Office is not responsible for payment for mileage or transportation to such meetings. \_\_\_\_\_ (initials)
19. Your application/enrollment process is not complete until you have completed your first day of training at your new training assignment. You will not be paid for any part of the application or enrollment process unless and until you have completed this first day of training. You will then be paid for all time spent previously during the application/enrollment process. \_\_\_\_\_ (initials)
20. I commit to conducting myself in a manner consistent with the highest standard of job responsibility that maintains Caritas Family Solutions SCSEP's reputation in the community. \_\_\_\_\_ (initials)

By signing this document, I acknowledge my understanding of the purposes of this program. If the program has vacancies, if I am found eligible, and if the program has the ability to meet my needs, I will be enrolled. If enrolled, I will receive the SCSEP Participant Handbook and orientation to the SCSEP. I will be provided with a copy of the Community Service Assignment Description for my training assignment. If enrolled, by signing I agree to comply with all policies and procedures of the SCSEP. I further understand that failure to comply with the terms of this agreement at any time during my time on the program could put my enrollment at risk and may result in my separation from the program.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Program Manager

\_\_\_\_\_  
Date



**RESOURCE(S):**

- Current Data Validation Handbook
- Most-in-Need Characteristics Handbook
- SCSEP Policy & Procedure Manual

Senior Community Service Employment Program

# Most-in Need (MIN) Re-Validation Form

Revised February 2021

**Instructions:**

- Appropriately file the completed form and the supporting documentation provided in the participant's file (*except medical information*).
- MIN factors must be re-validated once during each program year in order for you and the Center to get credit for the MIN performance measure.
- Enter the information from each completed MIN Form into the **Recertification/Waiver of Durational Limit** Tab in SPARQ to maintain MIN credit for the current program year.
- Must enter **YES** or **No** for each MIN characteristic in SPARQ.

Name of Subgrantee \_\_\_\_\_

Subgrantee Number \_\_\_\_\_

**Participant Name** \_\_\_\_\_  
First Middle Initial Last

Date met with participant \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

**Check All Either "No" or "Yes"**

1. **Birth Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

(available only to those who are 75 years or older on or before durational limit exit date)

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

2. **Limited English-speaking ability**

(available only to those who speak a language other than English as their primary language)

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

3. **Low literacy skills**

(available only to those who speak English as their primary language)

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

4. **Old enough for but not receiving Social Security Title II**

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

5. **Severe disability**

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

6. **Frail**

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

7. **Severely limited employment prospects in an area of persistent unemployment**

(two part MIN factor: participants must meet eligibility for both parts in order to apply)

a. **Severely limited employment prospects**

☐ No ☐ Yes

List of document(s) used to verify:  
\_\_\_\_\_

b. **And lives in an area of persistent unemployment**

☐ No ☐ Yes, as determined by USDOL

(refers to the Counties with Persistent Unemployment Report in SPARQ. No additional documentation needed)

**FOR USE BY STAFF ONLY**

\_\_\_\_\_  
Interviewer's Signature & Title

\_\_\_\_\_  
Project Staff (Final Review) Signature

Signature Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY



## ALL IN ONE MOST-IN-NEED (MIN) SELF-ATTESTATION FORM

**Name of Participant:** \_\_\_\_\_

I attest that the information stated below is true and accurate to the best of my understanding, and understand that if any of the information provided below is false, it may be grounds for immediate termination from the SCSEP program. **Check only those that apply.**

☐ **Homeless** — I lack a fixed, regular and adequate night-time residence because one of the following applies to me:

- |   |   |
|---|---|
| <input type="checkbox"/> I live in a shelter<br><input type="checkbox"/> I live in transitional housing<br><input type="checkbox"/> I live in a Welfare hotel | <input type="checkbox"/> I live in a temporary residence for individuals intending to be institutionalized; or<br><input type="checkbox"/> I live in a place not designed or ordinarily used as regular sleeping accommodations for people. |
|---|---|

*\*Automatically qualifies as Low Employment Prospects. Be sure to also check "Yes" to Q. #30 in SPARQ.*

☐ **Limited English Proficiency** — ☐ I do not speak English as my primary language, and  
☐ I have limited ability to read, speak, write or understand English. My primary language is \_\_\_\_\_.

*\*Automatically qualifies as Low Employment Prospects. Be sure to also check "Yes" to Q. #30 in SPARQ.*

☐ **Low Literacy Skills** — One or more of the following is true:

- ☐ I compute or solve problems, read, write or speak at or below the 8<sup>th</sup> grade level;
- ☐ I am unable to compute or solve problems, read, write or speak at a level necessary to function on the job, in my family or in society.

*\*Automatically qualifies as Low Employment Prospects. Be sure to also check "Yes" to Q. #30 in SPARQ.*

☐ **Veteran or Qualified Spouse of Veteran** (only when DD-214 is pending for Veterans discharged after 1950) — One or more of the following is true:

☐ I served in the active \_\_\_\_\_ and was discharged or released from such service under conditions other than dishonorable.

☐ I was on full-time duty in the National Guard or a reserve component, other than full-time duty for training purposes, and was released from such duty with other than dishonorable discharge.

☐ I am or was the spouse of a member of the US armed forces and that spouse is listed in one or more of the following categories:

- ☐ Missing in action,
- ☐ Captured in the line of duty by a hostile force,
- ☐ Forcibly detained or interned in the line of duty by a foreign government or power,
- ☐ Has a total disability permanent in nature resulting from a service-connected disability as determined by the VA, or
- ☐ Died while a disability so evaluated was in existence.

☐ **Failed to find employment after I enrolled in WIOA career services** on \_\_\_\_/\_\_\_\_/\_\_\_\_ and have been unemployed since \_\_\_\_/\_\_\_\_/\_\_\_\_.

*\*Enrollment requires verification from WIOA*

☐ **At risk for Homelessness** — I have a real and imminent risk of homelessness because:

- |  |  |
|--|--|
| <input type="checkbox"/> I often borrow money to pay my rent/mortgage;                                       | <input type="checkbox"/> I can't pay my rent/mortgage most months;                         |
| <input type="checkbox"/> My real estate taxes are unpaid or overdue;   | <input type="checkbox"/> I frequently have unpaid or overdue electric, gas or water bills; |
| <input type="checkbox"/> I am temporarily sharing space with a family member or friend;                      | <input type="checkbox"/> I have been evicted from a residence in the last 12 months;       |
| <input type="checkbox"/> I have involuntarily moved several times in the last year;                          | <input type="checkbox"/> I have lived in a shelter during the past 12 months;              |
| <input type="checkbox"/> My credit history and background disqualifies me from most rental/lease agreements; | <input type="checkbox"/> My rent/mortgage is unpaid; or                                    |
|  | <input type="checkbox"/> Other _____   |

☐ **Low Employment Prospects** because I have one or more of the following barriers:

- ☐ I lack a substantial employment history;
  - ☐ I lack a high school diploma or equivalent;
  - ☐ I have a documented disability; or
  - ☐ I have a significant barrier as described here \_\_\_\_\_.
- One or more of these barriers has prevented me from finding employment because \_\_\_\_\_
- \_\_\_\_\_

☐ **Severely Limited Employment Prospects** — I reside in \_\_\_\_\_ County and I have at least two of the following barriers:

- ☐ I lack substantial employment history,
  - ☐ I lack a high school diploma or equivalent,
  - ☐ I am homeless,
  - ☐ I have a documented disability, or
  - ☐ I have one or more significant barriers as described here: \_\_\_\_\_
- and one or more of these barriers has prevented me from finding employment because: \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
**PARTICIPANT'S SIGNATURE**

\_\_\_\_\_  
**PROJECT DIRECTOR'S SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**DATE**

The information provided in this form will be used solely to determine your eligibility for the SSAI SCSEP program and is not intended for any other purpose. The information will be treated as confidential information.

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**FOR SCSEP STAFF ONLY:**

**CASE NOTES:** \_\_\_\_\_

\_\_\_\_\_

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**See Data Validation handbook for any additional requirements to self-attest.**

Senior Community Service Employment Program (SCSEP)  
Community Service Assignment Description

Participant Name:	Assignment Title:
Host Agency:	Host Agency Address:
Host Agency Director / Supervisor:	Host Agency Phone No.:
Hours: 20 Hours	Days Working:
Wages: \$12.00 / hour	Beginning Assignment Date:

Duties and Responsibilities
Objective: New skill participant is projected to learn
Criteria for Selection/Requirement (Any particular skills, experience or training requirement of the assignment)
Training to be provided

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Project Director Signature

## Senior Community Service Employment Program

### RELEASE FORM

I \_\_\_\_\_ hereby authorize my employer (or employers) to

**(PARTICIPANT'S NAME)**

release any and all of my employment information (including but not limited to wages, hours of work and terms of employment) to the Center for Workforce Inclusion, or its sub-grantee, \_\_\_\_\_.

**(SUB-GRANTEE NAME)**

I understand that the Center for Workforce Inclusion or its sub-grantee will utilize this information for purposes consistent with the Senior Community Service Employment Program (SCSEP). The information will be used strictly for statistical purposes and will not be shared with anyone not associated with SCSEP. This Release is effective for 2 years from my date of hire into unsubsidized employment.

\_\_\_\_\_  
**PARTICIPANT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

**Employee's Withholding Certificate**

OMB No. 1545-0074

**2022**

- ▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**  
 ▶ **Give Form W-4 to your employer.**  
 ▶ **Your withholding is subject to review by the IRS.**

**Step 1:  
Enter  
Personal  
Information**

(a) <b>First name and middle initial</b>	<b>Last name</b>	(b) <b>Social security number</b>
<b>Address</b>		▶ <b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
<b>City or town, state, and ZIP code</b>		
(c) <input type="checkbox"/> <b>Single or Married filing separately</b> <input type="checkbox"/> <b>Married filing jointly or Qualifying widow(er)</b> <input type="checkbox"/> <b>Head of household</b> (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5.** See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App), and privacy.

**Step 2:  
Multiple Jobs  
or Spouse  
Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4); **or**  
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . ▶ ☐

**TIP:** To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

**Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs.** Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

<b>Step 3: Claim Dependents</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$		
	Multiply the number of other dependents by \$500 . . . ▶ \$		
	Add the amounts above and enter the total here . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b>	\$
	(b) <b>Deductions.</b> If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .	<b>4(b)</b>	\$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . .	<b>4(c)</b>	\$

**Step 5:  
Sign  
Here**

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ **Employee's signature** (This form is not valid unless you sign it.) ▶ **Date**

**Employers  
Only**

Employer's name and address	First date of employment	Employer identification number (EIN)
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## General Instructions

Section references are to the Internal Revenue Code.

### Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

**Exemption from withholding.** You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

**Your privacy.** If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

**Self-employment.** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to figure the amount to have withheld.

**Nonresident alien.** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Specific Instructions

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4 (optional).

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

**Step 2(b)—Multiple Jobs Worksheet** (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

**Note:** If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** \$ \_\_\_\_\_
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
  - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** \$ \_\_\_\_\_
  - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** \$ \_\_\_\_\_
  - c** Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** \$ \_\_\_\_\_
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** \_\_\_\_\_
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** \$ \_\_\_\_\_

**Step 4(b)—Deductions Worksheet** (Keep for your records.)

- 1** Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** \$ \_\_\_\_\_
- 2** Enter:  $\left\{ \begin{array}{l} \bullet \$25,900 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$19,400 \text{ if you're head of household} \\ \bullet \$12,950 \text{ if you're single or married filing separately} \end{array} \right\}$  . . . . . **2** \$ \_\_\_\_\_
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** \$ \_\_\_\_\_
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . . **4** \$ \_\_\_\_\_
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** \$ \_\_\_\_\_

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

**Married Filing Jointly or Qualifying Widow(er)**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$110	\$850	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,770	\$1,870
\$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
\$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
\$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
\$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
\$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
\$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
\$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
\$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
\$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
\$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
\$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
\$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
\$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
\$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
\$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
\$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
\$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$400	\$930	\$1,020	\$1,020	\$1,250	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970	\$2,040	\$2,040
\$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
\$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
\$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
\$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
\$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
\$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
\$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
\$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
\$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
\$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
\$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
\$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$760	\$910	\$1,020	\$1,020	\$1,020	\$1,190	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040
\$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
\$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
\$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
\$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
\$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
\$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
\$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
\$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
\$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
\$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
\$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
\$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730





**Note:** These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

### Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of a Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

If you are an Illinois resident who works for an employer in a non-reciprocal state but you work from home or in locations in Illinois for more than 30 working days, you may need to adjust your withholding or begin making estimated payments. For additional information, go to [tax.illinois.gov](http://tax.illinois.gov).

**Note** If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

### When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

IL-W-4 (R-05/20)

### When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

**Example:** If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

### How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

### What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

### What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (e.g., your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will

receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

**Note:** For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds \$500,000 for returns with a federal filing status of married filing jointly, or \$250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

### How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

**Note** If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

### How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than \$500 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at [tax.illinois.gov](http://tax.illinois.gov) to obtain a copy.

### Where do I get help?

- Visit our website at [tax.illinois.gov](http://tax.illinois.gov)
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to  
**ILLINOIS DEPARTMENT OF REVENUE  
PO BOX 19044  
SPRINGFIELD IL 62794-9044**

# Illinois Withholding Allowance Worksheet

## General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

## Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

- ☐ No one else can claim me as a dependent.  
☐ I can claim my spouse as a dependent.

- 1 Enter the total number of boxes you checked. 1 \_\_\_\_\_
- 2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. 2 \_\_\_\_\_
- 3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. 3 \_\_\_\_\_
- 4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 4 \_\_\_\_\_

## Step 2: Figure your additional allowances

Check all that apply:

- ☐ I am 65 or older. ☐ I am legally blind.  
☐ My spouse is 65 or older. ☐ My spouse is legally blind.

- 5 Enter the total number of boxes you checked. 5 \_\_\_\_\_
- 6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 \_\_\_\_\_
- 7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. 7 \_\_\_\_\_
- 8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. 8 \_\_\_\_\_
- 9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 9 \_\_\_\_\_

**IMPORTANT:** If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.



— — — — — Cut here and give the certificate to your employer. Keep the top portion for your records. — — — — —



Illinois Department of Revenue

## IL-W-4 Employee's Illinois Withholding Allowance Certificate

Social Security number \_\_\_\_\_

Name \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

- 1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 \_\_\_\_\_
- 2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 \_\_\_\_\_
- 3 Enter the additional amount you want withheld (deducted) from each pay. 3 \_\_\_\_\_

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature \_\_\_\_\_

Date \_\_\_\_\_



**Employment Eligibility Verification**  
**Department of Homeland Security**  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 10/31/2022

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [ ][ ] - [ ][ ] - [ ][ ][ ][ ]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	<div>QR Code - Section 1 Do Not Write In This Space</div>
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See instructions)  Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.  1. Alien Registration Number/USCIS Number: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 3. Foreign Passport Number: _____ Country of Issuance: _____	

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

**Preparer and/or Translator Certification (check one):**

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





**Employment Eligibility Verification**  
**Department of Homeland Security**  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 10/31/2022

**Section 2. Employer or Authorized Representative Review and Verification**

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

<b>Employee Info from Section 1</b>	<b>Last Name (Family Name)</b>	<b>First Name (Given Name)</b>	<b>M.I.</b>	<b>Citizenship/Immigration Status</b>
<b>List A</b> <b>Identity and Employment Authorization</b>	<b>OR</b>	<b>List B</b> <b>Identity</b>	<b>AND</b>	<b>List C</b> <b>Employment Authorization</b>
Document Title		<b>Document Title</b>		<b>Document Title</b>
Issuing Authority		<b>Issuing Authority</b>		<b>Issuing Authority</b>
Document Number		<b>Document Number</b>		<b>Document Number</b>
Expiration Date (if any) (mm/dd/yyyy)		<b>Expiration Date (if any) (mm/dd/yyyy)</b>		<b>Expiration Date (if any) (mm/dd/yyyy)</b>
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

**Certification:** I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

**The employee's first day of employment (mm/dd/yyyy):** \_\_\_\_\_ **(See instructions for exemptions)**

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

**Section 3. Reverification and Rehires** (To be completed and signed by employer or authorized representative.)

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
Last Name (Family Name)		First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		<b>For persons under age 18 who are unable to present a document listed above:</b>		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

**Examples of many of these documents appear in the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

I, \_\_\_\_\_  
(Name of Participant)

Understand that, as a service to me, the SCSEP is offering to pay for all or part of the cost of a physical examination. The results of the examination are my property, to share with the project director only if I so choose. I also understand that there may be some assignments which under law require health certification, and that I may be excluded from these if I do not have a physical examination.

Under these conditions fully, I choose:

- ☐ To have a physical examination; or
- ☐ To waive a physical examination.

\_\_\_\_\_  
(Signature of Participant)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Project Director)

\_\_\_\_\_  
(Date)



## SCSEP Case Management Note Form

(This form cannot be used as / is not an acceptable Self-Attestation Form)

**Name of Participant:** \_\_\_\_\_

1) Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

2) Name of person making note: \_\_\_\_\_

3) Date the following information was obtained: \_\_\_\_\_

4) Date the information was recorded (if different from #3): \_\_\_\_\_

Detailed Case Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

You can use this form if official documentation or other acceptable source documentation is not available for any of the items listed below. Complete 1-4, record the detailed note, and **check** ☒ the item below that this case note references.

### Assessed and captured only at time of enrollment for MIN:

- ☐ Homeless
- ☐ At risk for homelessness
- ☐ Low Employment Prospects--You must (a) identify the barrier(s) in notes above and (b) explain how the barrier(s) reduces the chances the participant will find employment. (No explanation is needed if the barrier is Homelessness, Limited English Proficiency, Limited Literacy Skills or documented Disability.)
- ☐ Failed to Find Employment after being enrolled in WIOA Title I Services or One-Stop Delivery System

### **Assessed at time of enrollment and revalidated once during each program year for MIN:**

- ☐ Limited English Proficiency
- ☐ Limited Literacy Skills

### Other uses:

- ☐ Number in family (must include reason information is accepted without signature)
- ☐ Unemployed at time of enrollment
- ☐ Approved break in service—Must include reason for break, date break begins and date break ends (if known)
- ☐ Quarterly training hours paid (Include who provided the training, where and when, etc.)
- ☐ Exit date
- ☐ FU: Wages for second or fourth quarter after Exit quarter (Is the participant employed in Q2 and/or Q4 post exit?)
- ☐ FU: Earnings for second quarter after Exit quarter (How much did the participant make in Q2 post exit?)
- ☐ Other \_\_\_\_\_  
(Use only if a case note is acceptable documentation.)

## ACTIVE Participant File Review Checklist

Participant Name:		Date of Enrollment:	
<b>Approved Break:</b>			
	Met	Not Met	N/A
Host Agency File Review			
HA name:			
Date service began:			
Host Agency monitoring			
Host Agency Safety Checklist			
Host Agency Orientation			
Current HA Agreement			
Agency Type : <input type="checkbox"/> Gov. or <input type="checkbox"/> Non-Profit			
If non-profit, 501(c)(3) determination letter			
Comments:			



## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

1. **Name of participant:** \_\_\_\_\_ 2. PID: \_\_\_\_\_  
Participant ID Number  
assigned by SPARQ
3. Name of grantee: \_\_\_\_\_

### Host Agency Information

4. Name of host agency: \_\_\_\_\_
5. Host agency mailing address: \_\_\_\_\_
- a. Number and Street, Suite Number; or PO Box \_\_\_\_\_
- b. City \_\_\_\_\_ c. State \_\_\_\_\_ d. ZIP Code \_\_\_\_\_
6. Federal Employer Identification No. (FEIN) \_\_\_\_\_
7. Host agency type: ☐ Not-for-profit ☐ Government
- 7a. Date of host agency agreement \_\_\_\_\_ (MM/DD/YYYY)
- 7b. Date of host agency monitoring visit \_\_\_\_\_ (MM/DD/YYYY)
8. Host agency site name and location \_\_\_\_\_

### Authorized for Local Reproduction

ETA-9121

(Revised November 2018; replaces prior versions)

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average six (6) minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Adult Services, Room S-4203, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).

Participant Name: \_\_\_\_\_ Page 1

Last First Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See the **Center Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

8a. Host agency job codes: i. _____ ii. _____ iii. _____		
<input type="checkbox"/> 1. Art, Design, Entertainment, Sports, and Media	<input type="checkbox"/> 8. Food Preparation and Service	<input type="checkbox"/> 15. Production, Assembly, Light Industrial
<input type="checkbox"/> 2. Business and Financial Operations	<input type="checkbox"/> 9. Healthcare	<input type="checkbox"/> 16. Protective Service
<input type="checkbox"/> 3. Community and Social Services	<input type="checkbox"/> 10. Legal	<input type="checkbox"/> 17. Retail, Sales, and Related
<input type="checkbox"/> 4. Computer and Mathematical	<input type="checkbox"/> 11. Maintenance and Custodial	<input type="checkbox"/> 18. Self-Employment
<input type="checkbox"/> 5. Construction, Installation, and Repair	<input type="checkbox"/> 12. Management	<input type="checkbox"/> 19. Transportation and Material Moving
<input type="checkbox"/> 6. Education, Training, and Library	<input type="checkbox"/> 13. Office and Administrative Support	
<input type="checkbox"/> 7. Farming, Fishing, and Forestry	<input type="checkbox"/> 14. Personal Care and Service	
8b. Host agency continued availability: <input type="checkbox"/> Available <input type="checkbox"/> Not available		

### Host Agency Contact/Supervisor Information

9. Name of contact person: \_\_\_\_\_

10. Contact person's mailing address if different from number 5:

a. Organization \_\_\_\_\_

b. Number and Street, Suite Number; or PO Box \_\_\_\_\_

c. City \_\_\_\_\_

d. State \_\_\_\_\_ e. ZIP Code \_\_\_\_\_

11. Contact person's title: \_\_\_\_\_

11a. Contact person's salutation ☐ Mr. ☐ Ms. ☐ Dr.

12. Contact person's phone number: \_\_\_\_\_

12a. Contact person's fax number: \_\_\_\_\_

12a1. Contact person's cell phone number: \_\_\_\_\_

12b. Contact person's email address: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Page 2

Last First Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

Complete fields 12c-12i if supervisor is different from contact person (number 9). If supervisor is the same as contact person, skip to field 12j.

12c.	Name of supervisor _____		
12d.	Supervisor's mailing address if different from number 5		
	_____		
	a. Organization		
	_____		
	b. Number and Street, Suite Number; or PO Box		
	_____		
	c. City		
	_____		
	d. State	e. ZIP Code	
12e.	Supervisor's title _____		
12f.	Supervisor's salutation <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		
12g.	Supervisor's phone number _____		
12h.	Supervisor's fax number _____		
12h1.	Supervisor's cell phone number _____		
12i.	Supervisor's e-mail address: _____		
12j.	Funding source of supervisor or contact person/supervisor:		
	<input type="checkbox"/> Federal <input type="checkbox"/> Non-federal \$_____(hourly rate)_____(average hours per week)		

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

### Assignment Information

13. Assignment date: \_\_\_\_\_ (MM/DD/YYYY)
14. Start assignment date: \_\_\_\_\_ (MM/DD/YYYY)
15. End date: \_\_\_\_\_ (MM/DD/YYYY)
- 15a. Approved break in participation Start date: \_\_\_\_\_ (MM/DD/YYYY)  
Expected end date: \_\_\_\_\_ (MM/DD/YYYY)  
Actual end date: \_\_\_\_\_ (MM/DD/YYYY)
- 15b. Reason for approved break in participation ♦
- ☐ i. Family/Health      ☐ iii. Administrative  
☐ ii. Personal      ☐ iv. Other (specify)

♦ **DV TIP:** To validate the reason for the approved break, provide detailed case notes that detail: (1) the reason for the break in participation, the start date and (if applicable) the end date of the break in participation; (2) and that the break was authorized through/in-line with your approved break policy.

- 15c. Comments on approved break in participation – detailed case note section ♦

Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

Name or initials of person making note: \_\_\_\_\_

Date the information was obtained: \_\_\_\_\_

Detailed Case Notes reflecting the reason for the break, the start date and if applicable (end date) and that the break is authorized through your approved break policy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Participant Name: \_\_\_\_\_ Page 4

Last      First      Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

16. Participant assigned to:

- ☐ i. Grantee or sub-recipient/local partner
- ☐ ii. Workforce partner
- ☐ iii. Other host agency

16a. If participant assigned to i or ii:

1. CSA wage (per hour) \$ \_\_\_\_\_
2. Number of hours per week assigned \_\_\_\_\_

16b. Participant's schedule

16c. Date of safety consultation with participant: \_\_\_\_\_ (MM/DD/YYYY)

17. Community service assignment code \_\_\_\_\_ (Select only one code from following lists.)

Service to the general community includes the following activities:

- |                                     |                                   |                           |
|-------------------------------------|-----------------------------------|---------------------------|
| G1. Education                       | G6. Environmental Quality         | G11. Counseling           |
| G2. Health and Hospitals            | G7. Public Works & Transportation | G12. Conservation         |
| G3. Housing and Home Rehabilitation | G8. Social Services               | G13. Community Betterment |
| G4. Employment Assistance           | G9. Legal                         | G14. Other: _____         |
| G5. Recreation, Parks, and Forests  | G10. Financial                    | _____                     |

Service to the elderly community includes the following activities:

- |                                     |                        |                           |
|-------------------------------------|------------------------|---------------------------|
| E1. Project Administration          | E6. Nutrition Programs | E11. Counseling           |
| E2. Health and Home Care            | E7. Transportation     | E12. Conservation         |
| E3. Housing and Home Rehabilitation | E8. Outreach/Referral  | E13. Community Betterment |
| E4. Employment Assistance           | E9. Legal              | E14. Other: _____         |
| E5. Recreation/Senior Centers       | E10. Financial         | _____                     |

18. Community service assignment title: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Page 5

Last

First

Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

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See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

18a. Participant's job code: \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> 1. Art, Design, Entertainment, Sports, and Media | <input type="checkbox"/> 8. Food Preparation and Service       | <input type="checkbox"/> 15. Production, Assembly, Light Industrial |
| <input type="checkbox"/> 2. Business and Financial Operations             | <input type="checkbox"/> 9. Healthcare                         | <input type="checkbox"/> 16. Protective Service                     |
| <input type="checkbox"/> 3. Community and Social Services                 | <input type="checkbox"/> 10. Legal                             | <input type="checkbox"/> 17. Retail, Sales, and Related             |
| <input type="checkbox"/> 4. Computer and Mathematical                     | <input type="checkbox"/> 11. Maintenance and Custodial         | <input type="checkbox"/> 18. Self-Employment                        |
| <input type="checkbox"/> 5. Construction, Installation, and Repair        | <input type="checkbox"/> 12. Management                        | <input type="checkbox"/> 19. Transportation and Material Moving     |
| <input type="checkbox"/> 6. Education, Training, and Library              | <input type="checkbox"/> 13. Office and Administrative Support |   |
| <input type="checkbox"/> 7. Farming, Fishing, and Forestry                | <input type="checkbox"/> 14. Personal Care and Service         |   |

18b. Participant's workers' compensation code \_\_\_\_\_

19. Total hours paid in quarter ♦

Quarter 1 \_\_\_\_\_ ♦

Quarter 3 \_\_\_\_\_ ♦

Quarter 2 \_\_\_\_\_ ♦

Quarter 4 \_\_\_\_\_ ♦

♦ **DV TIP #19** Use payroll records, timesheets, or paychecks issued to validate the number of hours per quarter.

20. Types of training received (Check all that apply). If no training was provided, enter "none."

- |   |   |
|---|---|
| <input type="checkbox"/> a. General training (basic skills)   | <input type="checkbox"/> d. Other specify _____ |
| <input type="checkbox"/> b. Specialized training (specific job/industry)<br>requires prior approval from SSAI | <input type="checkbox"/> e. None                |
| <input type="checkbox"/> c. On-the job-experience (OJE)<br>requires prior approval from SSAI                  |   |

♦ **DV TIP #20c.** Official subgrantee record that establishes the approval of an OJE for the Participant and the existence of signed contract. Verify training provider is not a host agency.

Participant Name: \_\_\_\_\_ Page 6

Last First Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

20a. 1. Type of supportive service provided:

<input type="checkbox"/> i. Dependent care (child or adult)	<input type="checkbox"/> v. Needs-related payments, such as utilities or food
<input type="checkbox"/> ii. Health and medical services	<input type="checkbox"/> vi. Special job-related or personal counseling
<input type="checkbox"/> iii. Housing, including temporary shelter	<input type="checkbox"/> vii. Transportation
<input type="checkbox"/> iv. Incidentals such as work shoes, badges, uniforms, eyeglasses, and tools	<input type="checkbox"/> viii. Other (specify) _____ _____

20a. 2. Date supportive service provided \_\_\_\_\_ (MM/DD/YYYY)

20a. 3. Supportive service provided by:

<input type="checkbox"/> i. Grantee or sub-recipient/local project
<input type="checkbox"/> ii. Workforce partner
<input type="checkbox"/> iii. Both i and ii
<input type="checkbox"/> iv. Other (specify) _____

21. Total hours of paid training received in quarter ♦ (exclude the community service hours the participant worked at his/her host agency):

Quarter 1 \_\_\_\_\_ ♦      Quarter 3 \_\_\_\_\_ ♦  
Quarter 2 \_\_\_\_\_ ♦      Quarter 4 \_\_\_\_\_ ♦

♦ **DV TIP #21** Use payroll records, timesheets, or paychecks issued to validate the number of training hours per quarter.

Participant Name: \_\_\_\_\_ Page 7  
Last First Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

### 22. Community service assignment comments

Name of source of the information: _____
His/her phone number: _____
His/her organization and title or relationship to participant: _____
Name or initials of person making note: _____
Date the information was obtained: _____
Detailed Case Notes: _____
_____

### Sub-Grantee Provided Training Information

(entire section not applicable unless you have a **Center-approved** OJE project)

#### Training Provider Information

23. Name of training provider or OJE employer: \_\_\_\_\_

24. Training provider or OJE employer mailing address

a. Number and Street, Suite Number; or PO Box

b. City

c. State

d. ZIP Code

25. Training provider continued availability: ☐ Available ☐ Not available

Participant Name: \_\_\_\_\_ Page 8  
Last First Middle



## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

### Contact Person Information

26. Name of training provider or OJE employer contactperson: \_\_\_\_\_

27. Contact person's mailing address if different from number 24

\_\_\_\_\_  
a. Organization

\_\_\_\_\_  
b. Number and Street, Suite Number; or PO Box

\_\_\_\_\_  
c. City

\_\_\_\_\_  
d. State

\_\_\_\_\_  
e. Zip Code

28. Contact person's title: \_\_\_\_\_

29. Contact person's salutation: ☐ Mr. ☐ Ms. ☐ Dr.

Participant Name: \_\_\_\_\_ Page 9  
Last First Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

30. Contact person's phone number: \_\_\_\_\_
31. Contact person's fax number: \_\_\_\_\_
- 31a. Contact person's cell phone number: \_\_\_\_\_
32. Contact person's e-mail: \_\_\_\_\_

### Training Information

33. Types of training received (Check only one per training record)
- ☐ a. General training (basic skills)
 ☐ d. Other (specify) \_\_\_\_\_
- ☐ b. Specialized training (specific job/industry)
- ☐ c. On-the-job-experience (OJE)
34. Job code for which training is provided, if relevant: \_\_\_\_\_
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> 1. Art, Design, Entertainment, Sports, and Media | <input type="checkbox"/> 8. Food Preparation and Service       | <input type="checkbox"/> 15. Production, Assembly, Light Industrial |
| <input type="checkbox"/> 2. Business and Financial Operations             | <input type="checkbox"/> 9. Healthcare                         | <input type="checkbox"/> 16. Protective Service                     |
| <input type="checkbox"/> 3. Community and Social Services                 | <input type="checkbox"/> 10. Legal                             | <input type="checkbox"/> 17. Retail, Sales, and Related             |
| <input type="checkbox"/> 4. Computer and Mathematical                     | <input type="checkbox"/> 11. Maintenance and Custodial         | <input type="checkbox"/> 18. Self-Employment                        |
| <input type="checkbox"/> 5. Construction, Installation, and Repair        | <input type="checkbox"/> 12. Management                        | <input type="checkbox"/> 19. Transportation and Material Moving     |
| <input type="checkbox"/> 6. Education, Training, and Library              | <input type="checkbox"/> 13. Office and Administrative Support |   |
| <input type="checkbox"/> 7. Farming, Fishing, and Forestry                | <input type="checkbox"/> 14. Personal Care and Service         |   |
35. Participant's workers' compensation code in training: \_\_\_\_\_
36. Start training date: \_\_\_\_\_ (MM/DD/YYYY)
37. End training date: \_\_\_\_\_ (MM/DD/YYYY)
38. Average number of hours of training per week: \_\_\_\_\_
39. Average number of hours of community service per week during training: \_\_\_\_\_
40. If OJE, wages paid by:
- ☐ Sub-grantee
 ☐ Employer and reimbursed by sub-grantee at rate of \_\_\_\_%

Participant Name: \_\_\_\_\_ Page 10

Last First Middle

## SCSEP Community Service Assignment Form

Fields marked with ♦ indicate a data validation field.

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See the **Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

41. Training wage (per hour): \$ \_\_\_\_\_
42. Total wages paid to participant or reimbursed to employer: \$ \_\_\_\_\_
43. Total amount paid to training provider for provision of training (other than reimbursement to employer)  
\$ \_\_\_\_\_
44. Training Comments:

Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

Name or initials of person making note: \_\_\_\_\_

Date the information was obtained: \_\_\_\_\_

Detailed Case Notes: \_\_\_\_\_

\_\_\_\_\_



# Safety Consultation and Host Agency Monitoring Form

Host Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Participant: \_\_\_\_\_ CSA Title: \_\_\_\_\_

## Safety Consultation:

Potential Hazardous Conditions/Areas and Items to Survey (S=Satisfactory; U=Unsatisfactory; NA=Not Applicable)	S	U	NA
Has your supervisor here talked with you about safety and what to do in case of emergency?			
Do you know where the nearest exit is?			
Have you been assigned a "buddy" to assist you in case of an emergency? (only applicable for participants with special needs)			
Do you know where the fire extinguisher is?			
Do you know what the procedures are in case of a fire?			
Do you know how to report an injury on the worksite?			
Please explain how you should report an injury?			
<b>Walkways, Steps, Entrance way and Parking areas</b>			
Are the floors defective?( broken tile, loose carpeting)			
Are sidewalks or parking areas free of: (potholes, cracks and debris?)			
Are there defective stairs or handrails?			
Are wet mats used and in good condition during rain/snow season?			
Are wet floor signs used?			
Does the participant know where or how to use the wet floor signs?			
Is there an adequate snow/ice removal plan in place?			
If needed does the participant have an alternate entrance way during snow/ice conditions?			
<b>Stairways, Hallways, and Common areas</b>			
Is there emergency lighting?			
Are the stairways free of debris? (i.e. boxes, storage in walkway)			
Do the stairways have non-slip treads?			
Are the handrails sturdy?			

## Safety Consultation and Host Agency Monitoring Form

Are the emergency exits clearly marked and exit doors accessible? (not blocked)			
Are there any wet floors?(check near water coolers, coffee machines, break rooms, rest rooms- anywhere spills can occur)			
Is there an emergency evacuation plan in uses and practiced (fire drills, etc.)?			
<b>Primary work area used by the participant</b>			
Is the participants station properly set up? Adjustable chairs, desks keyboards, mouse pads?			
Is the area free from potential slips, trips, and falls (are desk drawers shut, electrical cords and telephone cords routed away from walking areas and secured)			
Are the following acceptable for the participants work environment (Space condition, noise level, air quality/temperature, general cleanliness)?			
<b>Machinery, Tools and personal Protective equipment</b>			
Selection of the right tools: Are tools in good working condition?			
Are the right tools provided to the participant to complete the task? (Examples: headset for phone work, extension wands for hard to reach places, cutting boards, oven mitts, gloves, safety glasses, long sleeves and long pants for outdoor work.)			
Has the participant been trained on any new equipment/machinery?			
<b>Proper footwear</b>			
Does the participant know what type of footwear is proper for the assignment?			
Are safety shoes worn for landscaping or construction type work?			
Are non-slip shoes worn in housekeeping and food service type work?			
<b>Training and Lifting Requirements</b>			
Have participants been training in their duties prior to beginning new tasks?			
Have participants been trained in emergency procedures?			
Is participant aware of the lifting requirement for the Host Agency? If so, the participant may not lift more than _____ lbs.			

### Comments/Corrective Actions

Include positive feedback as well as items for improvement with planned date for corrective action in this section of the form.

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# Safety Consultation and Host Agency Monitoring Form

## Participant Interview:

1. Knowledge of the duties in the written community service assignment description and training plan:

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2. Satisfaction with the assignment and the level of supervision:

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3. Suggestions for changes, improvements or additional training:

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4. Updates for the Individual Employment Plan:

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5. Understanding of limit on the length of the assignment, payroll procedures and required benefits:

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6. Efforts to obtain unsubsidized employment:

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## Host Agency Supervisor(s) Interview:

Name(s): \_\_\_\_\_

1. Unsubsidized Placement Possibilities:

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2. Suggestions for changes in the CSA description, including placing participant in a role with increasing responsibility or additional training that will make the participant more employable:

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3. Compliance with Maintenance of Effort:

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4. Satisfaction with work being performed by participant and progress toward training plan:

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## Safety Consultation and Host Agency Monitoring Form

5. Has the Host Agency received a Customer Satisfaction Survey:
6. Host Agency provides appropriate supervision to participant and has proper controls to confirm hours reported on participant time sheets, including signatures of both participant and supervisor:

### Community Service Assignment Description Review:

1. Participants duties are the same as those described in the assignment description:
2. Participant Schedule as set forth in the assignment description is being followed:
3. Participant is acquiring the skills and confidence as outlined in the CSA description, training plan and IEP:

### Notes:

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SCSEP Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Participant Performance Evaluation

### A. Identification

Name of Participant: \_\_\_\_\_  
Assignment Title: \_\_\_\_\_  
Date of Assignment: \_\_\_\_\_  
Host Agency: \_\_\_\_\_  
Supervisor: \_\_\_\_\_

### B. Format of Performance Evaluation

The performance evaluation which follows has two sections:

- Section I: Categories of Evaluation
- Section II: Comments by the Participant

In Section I, the host agency supervisor is asked first to evaluate the participant in each of the eight categories of performance in the section. The evaluation should be based on performance and matched with the duties and responsibilities contained in the assignment description of the participant. Each section provides space for comments which should be specific whether favorable or unfavorable.

#### Section I: CATEGORIES OF EVALUATION

##### 1. *Quality*

The accuracy and completeness of duties performed as listed in the community service assignment description:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

##### 2. *Quantity and Organization*

The amount of service performed during a normal work period:

Comments: \_\_\_\_\_  
\_\_\_\_\_



### 3. *Attendance*

Reliability on coming to the assignment regularly and at assigned hours:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 4. *Interpersonal Skills*

The ability to relate with co-workers in a cooperative manner:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 5. *Interaction with Public*

How well does this participant interact with the public, with clients, or others? Is he/she courteous and patient?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 6. *Personal Appearance*

Does this participant dress appropriately for the assignment and maintain a well-groomed appearance consistent with assigned tasks?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 7. *Supervision*

Does this participant accept suggestions and directions well?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 8. *Overall Performance*

Taking into account all aspects of the participant's performance at the tasks assigned, the overall performance rating:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. *List accomplishments or goals mutually set by Participant, Supervisor and Project Director.*  
Specifically note if the participant is ready for unsubsidized employment at this host agency or other employment.

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(Signature of Host Agency Supervisor)

(Date)

## **Section II: COMMENTS BY THE PARTICIPANT**

After the supervisor has completed Section I, a copy must be given to and discussed with the participant. The participant being evaluated may make any comment on the evaluation, which has been provided, and should feel free to agree or disagree. The signature here does not mean agreement, unless stated, but means only that the participant has read the evaluation.

Do you agree or disagree with this evaluation? \_\_\_\_\_

Do you feel that the training you have received at this assignment has prepared you to obtain an unsubsidized job?

Yes ☐ No ☐

If yes, How? If no, Why not? \_\_\_\_\_

Comments by participant: \_\_\_\_\_

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(Signature of Participant)

(Date)

A copy of this performance evaluation must be given to the participant.

### **For Sponsor Project Use Only**

This Performance Evaluation is made Part of the IEP ☐ Yes ☐ No

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(Signature of Project Director)

(Date)

## Record of Host Agency Orientation

My signature here is acknowledgment that I have had fully explained to my satisfaction the following matters concerning my enrollment as a participant in the SCSEP:

	Goals of Center for Workforce Inclusion SCSEP
	Goals of the Caritas Family Solutions SCSEP
	Available supportive services for participants
	Training opportunities provided by Host Agency
	SCSEP participant meetings
	Obligation for participants to seek unsubsidized employment, including applying for jobs at Host Agency and registering with the One-Stop Career Center
	Community Service Assignment Description
	DOL mandated Host Agency Customer Satisfaction surveys
	Privacy Act of 1974 (copy of Statement to be given to the participant)
	Hours of community service
	Participant Wage rate
	Submission of timesheet and participant schedule
	Procedures for complaint resolution
	Procedures for reporting assignment-related accidents
	Participant Travel Policy
	Durational Limit for SCSEP participants
	Rotation policy for community service assignment
	Drug-free work place policy
	Reasons for termination from Host Agency and procedure
	Allowable and unallowable political activities for participants

Further, I have been given a copy of Caritas SCSEP Host Agency Policies and Procedures Handbook, and provided a copy of my organization's Community Service Assignment Description.

\_\_\_\_\_  
(Signature of Host Agency Supervisor)

\_\_\_\_\_  
(Date)

## SCSEP Host Agency Agreement PY2022

To comply with the requirements of the Center for Workforce Inclusion (CWI) Senior Community Service Employment Program (SCSEP), operated under Title V of the Older Americans Act, this Agreement is voluntarily entered by

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hereinafter referred to as the Host Agency, and \_\_\_\_\_,  
hereinafter referred to as the Sponsor Agency.

The Host Agency agrees to provide a safe and healthful work site for each participant, to provide the orientation and training necessary to perform assigned duties in accordance with a written community service assignment description, to provide additional training as opportunities occur, and, to the extent possible, treat each participant as a regular member of the Host Agency staff.

Regarding COVID guidelines, the Host Agency agrees to inform the Sponsor Agency of its policies regarding wearing masks, vaccines, and social distancing, including any and all amendments to these policies. Additionally, the Host Agency recognizes that the Sponsor Agency will be following applicable federal, state, and/or local COVID guidelines and will respect changes to SCSEP status that the Sponsor Agency may make in response to COVID.

The Host Agency is to immediately notify the Sponsor Agency if any participant has been exposed to the COVID virus, when applicable.

The Host Agency agrees to consider each participant for regular employment, either full-time or part-time, when vacancies occur in the Host Agency staff or when new positions are created. The Host Agency will also recommend suitable training for unsubsidized placement of the participant. A detailed training plan, which includes skills to be attained and timelines for achieving the goal, will be documented in the participant's Individual Employment Plan (IEP) and Community Service Assignment Description. The Community Service Assignment Description must specify the nature of the assignment, the hours each participant will train, specific duties and tasks to be performed.

As the onsite day-to-day supervisor of assigned participants, the Host Agency agrees to document any inappropriate work behaviors of participants that may lead to progressive discipline or other incidents and call and discuss with the Project Sponsor.

The Host Agency may allow an alternative or temporary community service assignment to include remote or telework. Such arrangements still require the Host Agency to provide

adequate supervision and equipment. Provision of the remote or telework assignment must be documented in the Community Service Assignment Description for Remote Work. The Host Agency must notify the Project Sponsor before initiating this type of assignment and agrees to requirements outlined in the Sponsor Agency's "SCSEP Remote Work Policy," and "Remote Work Approval Instructions." These documents will be provided by the Sponsor Agency upon request.

The Host Agency also agrees to notify the Project Sponsor of any unscheduled leave time of the participants, particularly absences of three days or longer.

The Host Agency understands that the length of time that a participant may remain in the same assignment will be determined in their Individual Employment Plan (IEP). The Host Agency understands that the Sponsor Agency may reassign any participant when that reassignment will increase the participant's opportunities for training or unsubsidized employment or will otherwise serve the best interests of the participant.

While this agreement is in effect, the Host Agency agrees to not provide community service assignments for participants serving through another national Title V project sponsor.

The Host Agency agrees to abide by the hours and work schedules mutually agreed to for each participant and to provide properly prepared time sheets (the supervisor will confirm that the participant worked the hours claimed on their time sheet and will assure that both they and the participant sign the time sheet); periodic performance evaluations; and other required documents. The Host Agency agrees and understands that each participant will be required to attend periodic SCSEP meetings during regular working hours.

The Host Agency agrees that the community service assignments for any participant are to be like "in demand" or "growth industries" private sector jobs, such as health care; child day care; education; or green jobs. However, these assignments will not result in the displacement of currently employed workers; or in a reduction in non-overtime hours of work, wages, or benefits; will not impair any existing contract for service or result in the substitution of the wages of the participant for other funds in connection with work which otherwise would be performed; will not be a substitution for any existing federally-assisted job; and will not be a position which is the same as or substantially the same as that occupied by any other person who is on lay-off or absent due to labor disputes. Further, the Host Agency agrees that it will not discriminate against a participant on the grounds of race, color, age, religion, sex, national origin, age, or disability.

The Host Agency agrees that participants currently assigned to the Host Agency are not permitted to volunteer at the Host Agency, whether it be similar activity as the Community Service Assignment or any other activity.

The Host Agency agrees to send a representative to a Host Agency supervisors' meeting. Host Agency supervisors' meetings will be held at least annually to acquaint all concerned with the SCSEP goals and objectives. The Host Agency agrees to participate in the DOL Customer Satisfaction Surveys if solicited.

The Host Agency agrees to provide documentation of in-kind contributions. Further, it is understood by the Host Agency and the Sponsor Agency that any contribution, whether cash or in-kind, by the Host Agency is purely voluntary and is not a condition for the assignment of any participant.

The Host Agency certifies by this Agreement that it is a governmental agency or is a non-profit agency which is currently certified as a Section 501(c) (3) organization under the Internal Revenue Code. In addition, the Host Agency will provide its Federal Employer Identification Number (FEIN). Further, if the Host Agency is certified as a Section 501(c) (3) agency, a copy of that certification is attached. The Host Agency agrees to inform the Sponsor Agency immediately if the Section 501(c) (3) certification is revoked.

The Sponsor Agency agrees to recruit, enroll, and assign a participant to the Host Agency for engaging in productive community service employment.

The Sponsor Agency agrees to be responsible for all administrative and fiscal controls of the SCSEP and for paying wages and providing fringe benefits to each participant. The Host Agency does not provide Workers' Compensation insurance for participants.

Indemnification. The Host Agency agrees to indemnify, defend and hold harmless the Sponsor Agency, its representatives, directors, officers, agents, invitees, participants and employees, and its Affiliates and their respective directors, officers, employers, participants and agents from and against any Claim for costs, fees, penalties, expenses, third-party damages, attorneys' fees and all other liabilities to any third party whatsoever ("Losses"), that result or arise from any allegation of bodily injury, death, or damage to real and/or tangible personal property, incurred during the activities and projects that arise from this Agreement, to the extent proximately caused by the negligence, gross negligence or intentional misconduct of the indemnifying party (i.e., Host Agency), its employees, partners, agents, invitees, participants and contractors.

"Claim" means any and all third-party claims, suits, and proceedings. Loss" means any and all losses, damages, costs, expenses, liabilities, obligations, judgments and claims of any kind (including reasonable attorneys' fees and all expenses and costs of investigation and litigation).

This indemnification provision shall survive the term of this Agreement, or any cancellation or abandonment of the terms and conditions contemplated herein.

Force Majeure. Under no circumstance will the Sponsor Agency be liable for any loss or damage caused by nonperformance due to circumstances beyond the Sponsor Agency's control, such as a pandemic, disease, natural disasters, war, acts of terrorism, civil unrest, and strikes.

This Agreement may not be amended except upon written agreement between the parties.

**This Agreement is in effective from  
July 1, 2022 to June 30, 2023**

**Definition of Host Agency Status**

(Check one)

- ☐ This host agency is a government agency. FEIN \_\_\_\_\_ (Required by USDOL).
- ☐ This host agency is a certified non-profit agency under Section 501(c) (3) of the United States Internal Revenue Code. FEIN \_\_\_\_\_ (Required by USDOL).  
\_\_\_\_\_ **501(c) (3) documentation is attached.**

**Signed ↓ Host Agency**

Host Agency: \_\_\_\_\_

Representative's Name: \_\_\_\_\_

Representative's Signature: \_\_\_\_\_

Host Agency Title: \_\_\_\_\_

Host Agency Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Date: \_\_\_\_\_

**Signed ↓ SCSEP Sponsor Agency**

SCSEP Sponsor: \_\_\_\_\_

Representative's Name: \_\_\_\_\_

Representative's Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Date: \_\_\_\_\_

## ACTIVE Participant File Review Checklist

Participant Name:		Date of Enrollment:	
<b>Approved Break:</b>			
File Review Element	Level of Compli.		
	Met	Not Met	N/A
<b>Initial Assessment/ Goal Setting</b>			
Initial Assessment completed on			
Contains work history			
Contains educational history, if any			
Records the hobbies and interest of the participant			
Lists the occupational preferences			
Records the participant's needs for supportive services			
Addresses training needs/occupation skills assessment			
Addresses job readiness			
Is signed by the participant and staff			



## SECTION 1: GENERAL INFORMATION

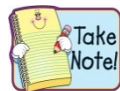
Participant Name: \_\_\_\_\_ Date of Initial Assessment: \_\_\_\_\_

1. How did you hear about the Senior Community Service Employment Program (SCSEP)?

☐ Newspaper ☐ Flyer ☐ Friend ☐ Word of Mouth ☐ Other \_\_\_\_\_

2. What are you hoping this program can provide for you?

☐ Some Financial Stability ☐ Socialization ☐ Training in new area ☐ Improve Computer Skills ☐ Other



The Senior Community Service Employment Program (SCSEP) is a program administered by the Department of Labor that serves unemployed low-income persons who are 55 years of age and older and who have poor employment prospects by training them in part-time community service assignments and by assisting them in developing skills and experience to facilitate their transition to unsubsidized employment. Participant Initial here \_\_\_\_\_

## SECTION 2: WORK HISTORY

Please complete the following work history beginning with your most recent employer.

<b>MOST RECENT EMPLOYER</b>		Select all that apply	Start Date	
JOB TITLE		<input type="checkbox"/> Paid	End Date	
DUTIES/SKILLS		<input type="checkbox"/> Unpaid <input type="checkbox"/> Volunteer <input type="checkbox"/> Military <input type="checkbox"/> Homemaker	Reason for Leaving:	
			Rate of Pay/Wages:	
			Hours per week:	
EMPLOYER		Select all that apply	Start Date	
JOB TITLE		<input type="checkbox"/> Paid	End Date	
DUTIES/SKILLS		<input type="checkbox"/> Unpaid <input type="checkbox"/> Volunteer <input type="checkbox"/> Military <input type="checkbox"/> Homemaker	Reason for Leaving:	
			Rate of Pay/Wages:	
			Hours per week:	
EMPLOYER		Select all that apply	Start Date	
JOB TITLE		<input type="checkbox"/> Paid	End Date	
DUTIES/SKILLS		<input type="checkbox"/> Unpaid <input type="checkbox"/> Volunteer <input type="checkbox"/> Military <input type="checkbox"/> Homemaker	Reason for Leaving:	
			Rate of Pay/Wages:	
			Hours per week:	

*Attach a copy of the individual's resume or refer to the American Job Center or available services for assistance in developing one.*

1. Which of your previous jobs did you enjoy most? \_\_\_\_\_ Why? \_\_\_\_\_
2. Would you consider doing the same type of work again? ☐ YES ☐ NO  
Why or Why not? \_\_\_\_\_
3. How many minutes or miles are you willing to travel to a job? \_\_\_\_\_
4. What have you been doing to find a job in the past year? \_\_\_\_\_
5. What type of job have you been looking for in the past year? \_\_\_\_\_
6. How long have you been out of work? \_\_\_\_\_
7. How long have you been looking for a job? \_\_\_\_\_
8. What kind of volunteer activities have you done in the last 30 days: \_\_\_\_\_
9. During the past year, have you worked with or been assisted by any other workforce development agency?  
\_\_\_\_\_
10. Do you have any Talents/Hobbies you didn't already mention? If so, what are they: \_\_\_\_\_

### SECTION 3: EDUCATION AND TRAINING HISTORY

*Select the highest level of education completed, field of study and date completed:*

Level of Education			
<input type="checkbox"/> GED or <input type="checkbox"/> H.S Diploma    Date Received _____	<input type="checkbox"/> Associates	<input type="checkbox"/> Bachelors	<input type="checkbox"/> Masters
<input type="checkbox"/> Other, Indicate grade level completed _____			
Date Completed			
Field of Study			

1. Do you have any job-related licenses or skills certifications? (e.g. LPN, welding, nurse aide, cosmetology, etc...) \_\_\_\_\_
2. Are you currently attending school, training, or any educational classes? \_\_\_\_\_  
If so, What? \_\_\_\_\_ and Where? \_\_\_\_\_

### SECTION 4: OCCUPATIONAL PREFERENCES

1. If you could get more training and instruction, what would be your perfect position?  
\_\_\_\_\_
2. Which of these work-related items are most important to you in a job right now? (Choose your top 3)
 

<input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Small office	<input type="checkbox"/> Large office	<input type="checkbox"/> Wages
<input type="checkbox"/> Lots of people	<input type="checkbox"/> Few people	<input type="checkbox"/> Busy	<input type="checkbox"/> Quiet	<input type="checkbox"/> Benefits
<input type="checkbox"/> Work in a team	<input type="checkbox"/> Work alone	<input type="checkbox"/> None	<input type="checkbox"/> Time and distance it takes to get to work	

3. Do you like working with **numbers and information**? This includes factual information, number specifications, research or data based information, codes, measurements, etc. **Examples** of this type of job may include accountant, bookkeeper, credit reporter, purchaser, claims adjuster, **cashier**, writing, filing, typing etc. ☐ Yes, Explain ☐ No, Explain
- 
4. Do you like working with **people**? This includes working directly with people or helping people. **Examples** of this type of job may include: **health care/social worker**, teacher, **nurse**, policeman, waitress, **receptionist**, etc. ☐ Yes, Explain ☐ No, explain
- 
5. Do you like working with **things**? This includes working with machinery, office equipment, shovels, tools, trucks, etc. **Examples** of this type of job may include **construction trades**, air conditioning and heating technicians, auto mechanics, auto body repairers, electricians, welders, truck drivers, **computer repairers**, machinist, general labors, **janitorial**, **custodian**, maintenance jobs etc. ☐ Yes, Explain ☐ No, Explain
- 

### Section 5: SUPPORTIVE SERVICE NEEDS CHECKLIST

Please use the checklist below to identify any other needs you have at this time:

<b>Transportation</b> <input type="checkbox"/> Get a valid driver's license <input type="checkbox"/> Get auto insurance, registration etc. <input type="checkbox"/> Get access to a working vehicle <input type="checkbox"/> Get help with gas money <input type="checkbox"/> Get help with public transportation	<b>Job Readiness/Job Search</b> <input type="checkbox"/> Get access to a computer or printer at home <input type="checkbox"/> Get internet access and an email address <input type="checkbox"/> Learn how to use a computer <input type="checkbox"/> Get access to a working answering machine or voice mail <input type="checkbox"/> Get a working cell phone <input type="checkbox"/> Develop a resume and cover letter <input type="checkbox"/> Learn to search for a job <input type="checkbox"/> Get proper interview clothing	<b>Housing</b> <input type="checkbox"/> Need basic essentials (food, clothing) <input type="checkbox"/> I want to live in my own place <input type="checkbox"/> Pay past due utilities <input type="checkbox"/> Get a telephone <input type="checkbox"/> Past due rent/mortgage <input type="checkbox"/> Rent will increase
<b>Health</b> <input type="checkbox"/> Get an eye exam/eye glasses <input type="checkbox"/> Reduce alcohol use <input type="checkbox"/> Reduce drug use <input type="checkbox"/> Get my teeth fixed, go to a dentist <input type="checkbox"/> Get personal grooming/hygiene items (make-up, toothpaste, soap, deodorant, etc.) <input type="checkbox"/> Need special accommodation due to: <input type="checkbox"/> Cannot lift over _____ pounds <input type="checkbox"/> Cannot sit or stand for long periods  Other: _____	<b>Personal/Family</b> <input type="checkbox"/> Develop confidence <input type="checkbox"/> Spend more time with others <input type="checkbox"/> Feel less frustrated, angry or confused <input type="checkbox"/> Get counseling for loss of a loved one <input type="checkbox"/> Learn money management skills <input type="checkbox"/> Pay family bills/debts <input type="checkbox"/> Needs for child/family care <input type="checkbox"/> Resolve/learn to address prior felonies or convictions	<b>Other</b> <input type="checkbox"/> SCSEP wages will decrease other benefits <input type="checkbox"/> Other Needs: _____  <input type="checkbox"/> Received referral/service from another source <input type="checkbox"/> Participant declined referral at this time <input type="checkbox"/> No referral resources available <input type="checkbox"/> No supportive needs at this time

### AGREEMENT

I agree that I have been an active participant in this assessment process. The information I gave for this assessment is true and correct.

Participant Signature

Date

Project Director/Staff Signature


Date



## FOR USE BY **SCSEP STAFF ONLY** BEYOND THIS POINT

This section of the participant's Initial Assessment is designed to allow you, SCSEP staff, the opportunity to reflect on the information you have collected to better assign the participant to a host agency that will provide the training and guidance best suited for this participant and centered on their best experience with the SCSEP program through the development of their Individual Employment Plan.

## Section 6: OCCUPATIONAL SKILLS ASSESSMENT

EDUCATION (BASIC SKILLS)	JOB KEEPING	JOB PREPARATION
<input type="checkbox"/> Does not have diploma or GED <input type="checkbox"/> Does not speak English fluently <input type="checkbox"/> Has Low Literacy Skills, unable to compute or solve problems, read, write, or speak at or above the 8th grade <input type="checkbox"/> Unable to compute or solve problems, read, write or speak at a level necessary function on the job, with family or in society. <input type="checkbox"/> Other _____	<input type="checkbox"/> Has not worked full-time (32+ hours a week) for at least ninety (90) days with one employer in the past year. (Ref: Employment History) <input type="checkbox"/> Has been fired from a job. <input type="checkbox"/> Has had problems with supervisors/co-workers in past. <input type="checkbox"/> Personal problems have interfered with employment in past. (potentially related to substance, mental health and/or behavioral issues) <input type="checkbox"/> Other _____	<input type="checkbox"/> Does not have a computer or printer at home <input type="checkbox"/> Does not have internet access or an email address <input type="checkbox"/> Does not know how to use a computer <input type="checkbox"/> Does not have a working answering machine or voice mail <input type="checkbox"/> Does not have a cell phone <input type="checkbox"/> Does not have a resume and cover letter <input type="checkbox"/> Has not searched for a job in several years <input type="checkbox"/> Has a history of underemployment in the last 10 years. <input type="checkbox"/> Other _____
Total of 1 or more checks indicates need for ADDITIONAL EDUCATION TRAINING. INDICATE TRAINING NEEDED ON THE ADDITIONAL EDUCATION TRAINING SECTION OF THE IEP.	Total of 1 or more checks indicates need for PARTICIPANT TO DEVELOP JOB KEEPING SKILLS AT THE COMMUNITY SERVICE ASSIGNMENT IN THE CSA SECTION OF THE IEP	Total of 1 or more checks indicates need to COMPLETE TASKS FOR JOB PREPARATION SKILLS OF THE INITIAL IEP
 <b>Remember to transfer and develop goals for checked items on the Initial IEP.</b>		

## Section 7: APTITUDE

PLEASE STAPLE A COMPLETED APTITUDE TEST TO THE ASSESSMENT. YOU MAY USE THE SAME FORMS YOU CURRENTLY USE OR THE FORMS RECOMMENDED BY the Center.

## Section 8: OVERALL ASSESSMENT

AFTER THE INITIAL ASSESSMENT INTERVIEW IS DONE, COMPLETE THIS SECTION AND MAKE CASE NOTES AS NEEDED ON THE ATTACHED CASE NOTE FORM.

Job Readiness Skills	Excellent	Good	Fair	Needs Improvement	Unable to Assess/ Re-Assessment Job Readiness Skills Month/Year
Participant's current potential for performing at an assigned community service agency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> / Date _____
Participant's current potential for transitioning to unsubsidized employment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> / Date _____

Identify three possible community service assignments based on the participant's preferences and potential employment goals.

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

NEXT REASSESSMENT and/or IEP APPOINTMENT: \_\_\_\_\_

**Schedule the next appointment and add to your calendar to assure follow-up.**

Grantees may not use SCSEP for job ready individuals who only need job search assistance or job referral services.

A Job Ready individual will have all three of the following criteria:

- ☐ **Hard** and **Soft** skills to do the job
- ☐ **Motivation**
- ☐ **Life Situation** is conducive to work (reliable transportation, health etc.)

If all Job Ready criteria are met, this participant is not eligible for SCSEP and should be referred to the American Job Center!

DO NOT ENROLL!



**CASE NOTE**

On \_\_\_\_\_, SCSEP staff obtained the following information: \_\_\_\_\_  
(Date)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SCSEP staff name/date of event and/or date recorded

\_\_\_\_\_  
Source of Information

\_\_\_\_\_  
Title or Relationship and phone number

\_\_\_\_\_  
Date information obtained

## ACTIVE Participant File Review Checklist

Participant Name:		Date of Enrollment:	
<b>Approved Break:</b>			
File Review Element	Level of Compli.		
	Met	Not Met	N/A
<b>Initial Individual Employment Plan (IEP)</b>			
Initial IEP completed on			
IEP completed within 90 days of enrollment.			
Lists long-term employment and education goal(s)			
Lists short-term goals with activities to attain goals			
Contains these sections: Additional Education/Training Community Service Assessment <input type="checkbox"/> Job Preparation <input type="checkbox"/> Unsubsidized Employment <input type="checkbox"/> Supportive Services <input type="checkbox"/>			
Signed by participant and staff member conducting IEP			

Participant Name:	Date of the Assessment this IEP is based on:
Name of Host Agency/ Assignment Title:	Date of this IEP to be entered into SPARO:
Long-Term Employment Goal(s):	Long-Term Education Goal(s):

### SHORT-TERM SCSEP GOALS

GOAL(S)	ACTIVITIES TO ATTAIN GOALS	INITIATION DATE	EXPECTED COMPLETION DATE	CURRENTLY EXISTS OR DATE COMPLETED
I will prepare for SCSEP	<input type="checkbox"/> Register with the local American Job Center (AJC) and provide the letter verifying that I have done so to SCSEP staff. <input type="checkbox"/> Start to plan readiness to go to work. (e.g. scheduling appointments around work time, prepare to dedicate time and energy to working and training.)			<input type="checkbox"/> /_____ Date completed <input type="checkbox"/> /_____ Date completed
I will update my CONTACT INFORMATION	<input type="checkbox"/> Obtain a working phone with an answering machine or voice mail. <input type="checkbox"/> Create a professional answering machine or voicemail message for missed calls. <input type="checkbox"/> Create a professional email address and if applicable update resume with same email. <input type="checkbox"/> Obtain and/or identify free access to a computer <input type="checkbox"/> Establish and/or update a minimum of one online profile (Facebook, LinkedIn,) to make sure my public image is professional ( <i>if applicable</i> )			<input type="checkbox"/> /_____ Date completed <input type="checkbox"/> /_____ Date completed <input type="checkbox"/> /_____ Date completed <input type="checkbox"/> /_____ Date completed <input type="checkbox"/> /_____ Date complete
I will update my SUPPORT NETWORK	<input type="checkbox"/> Create a network list of friends and business associates who I can call on for help with editing my resume, job leads, coaching, and other employment related assistance. <input type="checkbox"/> Develop a list of references (co-workers, supervisors, people you have supervised, vendors, customers, etc.) who I am in contact with, who know my work well enough to be able to provide me with a strong employment reference.			<input type="checkbox"/> /_____ Date completed  <input type="checkbox"/> /_____ Date completed



### ADDITIONAL EDUCATION TRAINING

Please refer to the **Education Basic Skills** column in Section 6 of the Initial Assessment to develop short-term goals and action steps for this section.

SMART GOAL(S)	SMART ACTION STEPS TO ATTAIN GOAL(S)	INITIATION DATE	EXPECTED COMPLETION DATE	ACTUAL COMPLETION DATE

### COMMUNITY SERVICE ASSIGNMENT

Please refer to the **Job Keeping** column in Section 6 of the Initial Assessment to develop short-term goals and action steps for this section.

SMART GOAL(S)	SMART ACTION STEPS TO ATTAIN GOAL(S)	INITIATION DATE	EXPECTED COMPLETION DATE	ACTUAL COMPLETION DATE

### JOB PREPARATION

Please refer to the **Job Preparation** column in section 6 of the Initial Assessment to develop short-term goals and action steps for this section.

SMART GOAL(S)	SMART ACTION STEPS TO ATTAIN GOAL(S)	INITIATION DATE	EXPECTED COMPLETION DATE	ACTUAL COMPLETION DATE

### UNSUBSIDIZED EMPLOYMENT

Please refer to the **Initial Assessment** to develop new action steps related to a specific unsubsidized job.

SMART GOAL(S)	SMART ACTIVITIES TO ATTAIN GOAL(S)	INITIATION DATE	EXPECTED COMPLETION DATE	ACTUAL COMPLETION DATE

### SUPPORTIVE SERVICES

Please refer to the **Supportive Services** section 5 of the Initial Assessment to develop new supportive service referrals

Additional Actions To Be Taken/Initiated			
Actions	Resources	Initiation Date	Completion Date

**Please check any that apply:**  
☐ Received referral/service from another source; ☐ Participant declined referral at this time; ☐ No referral resources available  
☐ No supportive needs at this time

### AGREEMENT

This IEP is a plan, roadmap and skill building agreement that is designed to lead you to an unsubsidized placement. By signing below, the **Participant** and **SCSEP Project Director** agree with the outlined plan and understand the level of commitment needed to achieve the proposed goals. If at any time the participant breaks this contract, (s)he may be subject to termination from the SCSCP Program.

I understand that this plan will help me in obtaining unsubsidized employment through my community service assignment and training received at \_\_\_\_\_ host agency. I have assisted in the completion of my Individual Employment Plan (IEP) and I agree with the listed steps to be completed. I also understand that failure to follow through on this plan may result in disciplinary action, up to and including termination from the program.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Project Director/ Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

## ACTIVE Participant File Review Checklist

Participant Name:		Date of Enrollment:	
<b>Approved Break:</b>			
File Review Element	Level of Compli.		
	Met	Not Met	N/A
Reassessment/ IEP Update			
Dates of last two IEP/Reassessments			
1. 2.			
Participant's assessment of the host agency			
Supportive Services Needs updated			
Shows timeline for achieving goals and action steps			
Is signed by the participant and staff			
Records employment skills and readiness			
Records follow-up on referred supportive services			
Signed by participant and staff member conducting update			

**RE-ASSESSMENT**

Participant Name: \_\_\_\_\_ Date of Reassessment: \_\_\_\_\_

Current Host Agency: \_\_\_\_\_ Assignment Title: \_\_\_\_\_

**Section 1: HOST AGENCY ASSIGNMENT –Participant Assessment**

1. What has been an important achievement for you since starting this assignment?

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2. What new skills have you developed since the last re-assessment?

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3. Have you been re-assigned to a new host agency since the last assessment? If so, please explain.

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4. Has your host agency supervisor had to speak with you about any problems you may have had or be having at your host agency? If so, please explain.

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5. Are there any new things you think you can learn at your current host agency? If so, please explain.

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6. How well do you get along with the other staff and/or participants at your host agency?

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7. How are you a team player at your host agency?

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8. How can you better use your host agency to improve your job readiness?

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9. Are you having any challenges or issues at your host agency, if so, please explain?

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### ACTIVE Participant File Review Checklist

Participant Name:		Date of Enrollment:	
<b>Approved Break:</b>			
File Review Element	Level of Compli.		
	Met	Not Met	N/A
Durational Limit & Transition Assess./IEP			
Transitional Assessment/IEP completed on _____, and _____.			
Transition Assessment/IEP completed within 12 months, 90 days, and 30 days of DL			
DI notice sent on _____, and _____.			
DL notice completed within 12 months, 90 days, and 30 days of the participant's DL.			

## EXITED (INACTIVE) Participant File Review Checklist

<b>Participant Name:</b>				<b>Exit Date:</b>			
<b>Exit Type:</b>							
File Review Element	Level of Compli.			File Review Element	Level of Compli.		
	Met	Not Met	N/A		Met	Not Met	N/A
<b>Program Documentation for Exit</b>				<b>Durational Limit (DL) and Transition Assessment/IEP</b>			
Exit Form completed				Transition Assessment/IEP completed on _____, _____ and _____			
UE Form completed				Transition Assessment/IEP completed within 12 months, 90 days, and 30 days of participant's DL			
Follow-up 1 includes appropriate docs for: <input type="checkbox"/> Wages <input type="checkbox"/> Earnings <input type="checkbox"/> Case notes and <input type="checkbox"/> Signatures				Supportive Services Needs updated			
Follow-up 2 includes appropriate docs for: <input type="checkbox"/> Wages <input type="checkbox"/> Earnings <input type="checkbox"/> Case notes and <input type="checkbox"/> Signatures				Shows timeline for achieving goals and action steps			
Follow-up 3 includes appropriate docs for: <input type="checkbox"/> Wages <input type="checkbox"/> Earnings <input type="checkbox"/> Case notes and <input type="checkbox"/> Signatures				Is signed by the participant and staff			
Documentation present for exit reasons other than UE				Records employment skills and readiness			
Grievance Records				DL notice sent on _____, _____ and _____			
Comments:				DL notice is completed within 12 months, 90 days, and 30 days of participant's DL			
				Records follow-up on referred supportive services			

## SCSEP Exit Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

### Exit Information

1. Name of participant: \_\_\_\_\_
2. PID: \_\_\_\_\_  
Participant ID Number  
assigned by SPARQ
3. Participant mailing address  
\_\_\_\_\_  
a. Number and Street, Apt. Number; or PO Box  
\_\_\_\_\_  
b. City \_\_\_\_\_ c. County \_\_\_\_\_  
d. State \_\_\_\_\_ e. ZIP Code \_\_\_\_\_
4. Phone number of participant (home) \_\_\_\_\_ (cell) \_\_\_\_\_  
**This information is key for conducting required follow-ups after exit.**
- 4b. Email address (if applicable): \_\_\_\_\_  
**This information is key for conducting required follow-ups after exit.**
5. Exit due to unsubsidized placement? (Select one only) Complete unsubsidized placement form if you answer "yes" to this question.  
☐ i. Yes, regular employment      ☐ ii. Yes, self-employment      ☐ iii. No

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ETA-9123

**(Revised November 2018; replaces prior versions)**

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Participant Name \_\_\_\_\_  
Last First Middle

Page 1



## SCSEP Exit Form

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Shaded areas indicate data fields that are optional.

6.1 For PY18, if exit is not due to unsubsidized employment, other reason for exit (Select one only)

- ☐ i. Moved from area    ☐ ii. For cause ▲    ☐ iii. Voluntary    ☐ iv. Durational limit ▲  
☐ v. Deceased♦

♦ **DV TIP:** Death record or certification; or death notice published through the Internet, in newspaper, and local funeral homes or 3<sup>rd</sup> party attestation, or detailed case notes.

- ☐ vi. Participant's Health/  
medical♦

**DV TIP:** Self-attest or 3<sup>rd</sup> party attest; or medical records or other official records including but not limited to actual medical records, physician's statement or other certification from a medical professional, letter from official at a medical facility or institution, psychologist's diagnosis, rehabilitation evaluation, disability records, Veteran's medical records, vocational rehabilitation letter, workers' compensation record; or detailed case notes.

- ☐ vii. Institutionalized♦

**DV TIP:** Self-attest or 3<sup>rd</sup> party attest form; or medical records or other official records including but not limited to actual medical records, physician's statement or other certification from a medical professional, letter from official at a medical facility or institution, psychologist's diagnosis, rehabilitation evaluation, disability records, Veteran's medical records, vocational rehabilitation letter, workers' compensation record; or detailed case notes.

- ☐ viii. Reserve personnel called to active duty  
☐ ix. Ineligible due to income at recertification▲

▲ Indicates type of exit that requires 30-day written notice be provided to participant before exit.

6a. Non-exit reasons for closing the record (Select one only)

- ☐ i. Withdrew application prior to assignment/withdrew from waiting list  
☐ ii. \* Transferred to another project (specify other grantee's code) \_\_\_\_\_  
☐ iii. \* Moved to another sub-grantee (specify sub-grantee code) \_\_\_\_\_  
☐ iv. Dual Enrollment (with another SCSEP grantee)

\* No data entry in SPARQ. Field is system-generated

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Exit Form

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Shaded areas indicate data fields that are optional.

6b. Date of termination letter \_\_\_\_\_ (MM/DD/YYYY)

**♦ DV TIP**

For all exits involving involuntary exits (30 days before exit letter) letter must exist with date of termination.

7. Date of exit or other closing of record \_\_\_\_\_ (MM/DD/YYYY) ♦

**♦ DV TIP #7**

To validate the date of exit, you can use subgrantee records such as: payroll records, termination letter; the signature on the Exit waiver of confidentiality (if applicable) or detailed case notes.

### Waiver of Confidentiality

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
[name of participant] [name of employer]

to release to \_\_\_\_\_ information regarding my employment status  
[name of sub-grantee]

and wages for a period of **24 months from the unsubsidized employer hire date**. This information may be used solely for statistical purposes and may not be disclosed to anyone not connected with the Senior Community Service Employment Program (SCSEP) in a manner that is individually identifying.

8. Signature of participant \_\_\_\_\_ (only have participant sign if they are exiting for unsubsidized placement and execute confidentiality waiver above; otherwise, leave blank)

9. Date of signing \_\_\_\_\_ (MM/DD/YYYY) (applies to #8 above only otherwise leave blank).

Participant Name \_\_\_\_\_  
Last First Middle

## SCSEP Exit Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

---

9c. Has the participant died since exiting? ☐ Yes ☐ No

10. Exit comments – detailed case note section ♦

Name of source of the information: _____
His/her phone number: _____
His/her organization and title or relationship to participant: _____
Name or initials of person making note: _____
Date the information was obtained: _____
Detailed Case Notes: _____
_____
_____

Participant Name \_\_\_\_\_  
Last First Middle

## **SCSEP Excluded Exits Self-Attest Form**

**New: All exclusions can only be captured at the time of exit.**

On this date, I, \_\_\_\_\_ (*Name of Participant*), certify that I am unable to continue participating in the SCSEP program and unable to work based on one of the following:

\_\_\_\_\_ I have a documented health/medical exclusion, that is:

1. I am in the care of Dr. \_\_\_\_\_ (*Name of Doctor*), **and**
2. I have been informed by Dr. \_\_\_\_\_ (*Name of Doctor*), that
  - a. my medical condition is expected to last at least 90 days, **and**
  - b. my medical condition prevents me from continued participation in the SCSEP program or from working.

\_\_\_\_\_ I am institutionalized, that is:

1. I am receiving 24-hour care at \_\_\_\_\_ (*Name of facility*), which is a facility such as a jail, prison, hospital, or rehabilitation center; **and**
2. I have been informed by \_\_\_\_\_ (*Name and Position*), that I am expected to remain at this facility for at least 90 days, which prevents me from continued participation in the SCSEP program or from working.

\_\_\_\_\_  
(*Signature of Applicant*)

\_\_\_\_\_  
(*Date*)

## SCSEP Unsubsidized Employment Form

Fields marked with ♦ indicate a data validation field.

You must secure acceptable validation documentation.  
See **the Center's Data Validation Checklist** for further instructions.

Shaded areas indicate data fields that are optional.

1. Name of participant: \_\_\_\_\_ 2. PID: \_\_\_\_\_  
Participant ID Number  
assigned by SPARQ

### Employer Information

3. Name of employer \_\_\_\_\_  
Name of organization or employer

4. Employer mailing address

a. Number and Street, Suite Number; and/or PO Box

b. City

c. State

d. Zip Code

5. Federal Employer Identification Number (FEIN) \_\_\_\_\_

6. Employer type (select one)

☐ Not-for-profit  
☐ Government

☐ For-profit  
☐ Self-employment Self-employment may be verified by any proof that the individual has started a business, such as tax registration, business cards or invoices, or a state license. The individual does not have to prove income from the business, but the receipt of income would suffice to establish self-employment.

7. Is employer a host agency? ☐ Yes ☐ No

8. Did employer provide an OJE training site for this participant? ☐ Yes ☐ No ♦

**8. ♦ DV TIP:** Official subgrantee record that establishes the approval of an OJE for the Participant and the existence of a signed contract.

#### Authorized for Local Reproduction

ETA-9122

(Revised November 2018; replaces prior versions)

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average six (6) minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Adult Services, Room S-4203, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).

Participant Name \_\_\_\_\_ Page 1  
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## SCSEP Unsubsidized Employment Form

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9. Employment site name and location \_\_\_\_\_

9a. ♦Date for next customer satisfaction survey for this employer \_\_\_\_\_

9b. Employer continued availability ☐ Available ☐ Not available

### Employer Contact/Supervisor Information

10. Name of contact person: \_\_\_\_\_

11. Contact person's mailing address if different from number 4

a. Organization name \_\_\_\_\_

b. Number and Street, Suite Number; and/or PO Box \_\_\_\_\_

c. City \_\_\_\_\_

d. State \_\_\_\_\_

e. ZIP Code \_\_\_\_\_

12. Contact person's title: \_\_\_\_\_

12a. Contact person's salutation: ☐ Mr. ☐ Ms. ☐ Dr.

13. Contact person's phone number \_\_\_\_\_

13a. Contact person's fax number \_\_\_\_\_

13a1. Contact person's cell phone number \_\_\_\_\_

13b. Contact person's e-mail address \_\_\_\_\_

\* No data entry in SPARQ. Field is system-generated.

Participant Name \_\_\_\_\_ Page 2  
Last First Middle

**Shaded areas indicate data fields that are optional.**

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# SSAI SCSEP Unsubsidized Employment Form

OMB Approval Number: 1205-0040  
Expiration Date: Not Applicable

Fields marked with ♦ indicate a data validation field.

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See the SSAI Data Validation Checklist for further instructions.

Shaded areas indicate data fields that are optional.

17. Benefits (check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> a. Health insurance       | <input type="checkbox"/> d. Vacation       | <input type="checkbox"/> g. Other _____ (specify) |
| <input type="checkbox"/> b. Sick leave             | <input type="checkbox"/> e. Transportation | <input type="checkbox"/> h. None                  |
| <input type="checkbox"/> c. Pension/profit sharing | <input type="checkbox"/> f. Room and board |   |

18. At time of placement, is employment expected to be full- or part-time?

- ☐ Full-time    ☐ Part-time

Full-time work means work of at least 40 hours per week, or such lesser amount as determined by the employer, to constitute full-time work.

If part-time, number of hours per week expected: \_\_\_\_\_

19. Unsubsidized job title: \_\_\_\_\_

19a. Participant's job code: \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> 1. Art, Design, Entertainment, Sports, and Media | <input type="checkbox"/> 8. Food Preparation and Service       | <input type="checkbox"/> 15. Production, Assembly, Light Industrial |
| <input type="checkbox"/> 2. Business and Financial Operations             | <input type="checkbox"/> 9. Healthcare                         | <input type="checkbox"/> 16. Protective Service                     |
| <input type="checkbox"/> 3. Community and Social Services                 | <input type="checkbox"/> 10. Legal                             | <input type="checkbox"/> 17. Retail, Sales, and Related             |
| <input type="checkbox"/> 4. Computer and Mathematical                     | <input type="checkbox"/> 11. Maintenance and Custodial         | <input type="checkbox"/> 18. Self-Employment                        |
| <input type="checkbox"/> 5. Construction, Installation, and Repair        | <input type="checkbox"/> 12. Management                        | <input type="checkbox"/> 19. Transportation and Material Moving     |
| <input type="checkbox"/> 6. Education, Training, and Library              | <input type="checkbox"/> 13. Office and Administrative Support |   |
| <input type="checkbox"/> 7. Farming, Fishing, and Forestry                | <input type="checkbox"/> 14. Personal Care and Service         |   |

19b. High-growth industry placement (select one)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> 1. Automotive             | <input type="checkbox"/> 6. Financial Services      | <input type="checkbox"/> 11. Retail         |
| <input type="checkbox"/> 2. Advanced Manufacturing | <input type="checkbox"/> 7. Geospatial              | <input type="checkbox"/> 12. Transportation |
| <input type="checkbox"/> 3. Biotechnology          | <input type="checkbox"/> 8. Health Care             | <input type="checkbox"/> 13. None           |
| <input type="checkbox"/> 4. Construction           | <input type="checkbox"/> 9. Hospitality             |   |
| <input type="checkbox"/> 5. Energy                 | <input type="checkbox"/> 10. Information Technology |   |

20. Is the job a training-related placement? This means is the participant's unsubsidized job related to the host agency training or other training they received from SCSEP?    ☐ Yes    ☐ No

21. Was placement the result of a substantial service provided to the employer by the subgrantee?

- ☐ Yes    We referred the applicant to the employer and the employer was aware of the referral.
- ☐ No    The participant found the job solely on his/her own, the participant is self-employed, or we referred the applicant to the employer without making the employer aware of the referral.

Participant Name \_\_\_\_\_ Page 4  
Last First Middle



## SCSEP Unsubsidized Employment Form

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21a. Type of supportive service provided:

- |  |   |
|--|---|
| <input type="checkbox"/> i. Dependent care (child or adult)  | <input type="checkbox"/> v. Needs-related payments, such as utilities or food |
| <input type="checkbox"/> ii. Health and medical services   | <input type="checkbox"/> vi. Special job-related or personal counseling       |
| <input type="checkbox"/> iii. Housing, including temporary shelter                                   | <input type="checkbox"/> vii. Transportation                                  |
| <input type="checkbox"/> iv. Incidentals such as work shoes, badges, uniforms, eyeglasses, and tools | <input type="checkbox"/> viii. Other (specify) _____                          |

21b. Date supportive service provided \_\_\_\_\_ (MM/DD/YYYY)

21c. Supportive service provided by:

- ☐ i. Grantee or sub-recipient/local project
- ☐ ii. Workforce partner
- ☐ iii. Both i and ii
- ☐ iv. Other (specify) \_\_\_\_\_
- \_\_\_\_\_

22. Unsubsidized employment comments:

Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

Name or initials of person making note: \_\_\_\_\_

Date the information was obtained: \_\_\_\_\_

Detailed Case Notes: \_\_\_\_\_

\_\_\_\_\_

## SCSEP Unsubsidized Employment Form

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### Employer Customer Service (CS) Survey Information

See SCSEP Policy and Procedure #900-D for Instructions regarding  
the Employer Satisfaction Survey.

23. CS survey number 1 \_\_\_\_\_ Date \_\_\_\_\_ (MM/DD/YYYY)
24. CS survey number 2 \_\_\_\_\_ Date \_\_\_\_\_ (MM/DD/YYYY)
25. CS survey number 3 \_\_\_\_\_ Date \_\_\_\_\_ (MM/DD/YYYY)
- 

### Follow-up Information

26. \*90-day date \_\_\_\_\_ (MM/DD/YYYY)
27. Has the participant returned to program within the first 90 days after exit? ☐ Yes ☐ No
- 27a. Has the participant re-enrolled in SCSEP within the first 90 days after exit? ☐ Yes ☐ No

\*No data entry in SPARQ. Field is system-generated.

Participant Name \_\_\_\_\_ Page 6  
Last First Middle

## SCSEP Unsubsidized Employment Form

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### 32. PY18 Follow-up 1

- a. \*Scheduled date: \_\_\_\_\_ (MM/DD/YYYY)
- b. Completed date: \_\_\_\_\_ (MM/DD/YYYY)
- c. Any wages for second quarter after exit quarter? ♦ Please also indicate method of verification
  - i. ☐ No wages
  - ii. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer ♦

#### 32c. ii ♦ DV TIP:

Self-attest form, secure pay stubs, written statement from employer, or detailed case notes to validate.

### 33. PY18 Follow-up 2

- a. \*Scheduled date: \_\_\_\_\_ (MM/DD/YYYY)
- b. Completed date: \_\_\_\_\_ (MM/DD/YYYY)
- c. Earnings for second quarter after exit quarter \$ \_\_\_\_\_

#### 33c. ♦ DV TIP:

Earnings information must come from pay stubs, or a written statement of earnings from the employer, or case notes based on information from the employer.

### 34. PY18 Follow-up 3

- a. \*Scheduled date: \_\_\_\_\_ (MM/DD/YYYY)
- b. Completed date: \_\_\_\_\_ (MM/DD/YYYY)
- c. Any wages for fourth quarter after exit quarter? ♦ Please also indicate method of verification
  - i. ☐ No wages
  - ii. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer ♦

#### 34c. ii ♦ DV TIP:

Self-attest form, secure pay stubs, written statement from employer, or detailed case notes to validate.

\*No data entry in SPARQ. Field is system-generated.

Participant Name \_\_\_\_\_ Page 7  
Last First Middle

## SCSEP Unsubsidized Employment Form

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Shaded areas indicate data fields that are optional.

### 35. Customer satisfaction and follow-up comments:

Name of source of the information: \_\_\_\_\_

His/her phone number: \_\_\_\_\_

His/her organization and title or relationship to participant: \_\_\_\_\_

Name or initials of person making note: \_\_\_\_\_

Date the information was obtained: \_\_\_\_\_

Detailed Case Notes: \_\_\_\_\_

# CARITAS FAMILY SOLUTIONS SCSEP PARTICIPANT TABLET CHECKOUT AGREEMENT



**PLEASE PRINT ALL INFORMATION:**

Participant	Last Name	First Name	Payroll #
	County	Driver's License # / State ID #	Tablet Unit #
Address			
Phone #:		E-mail	

In this agreement, "we," "us," and "our" means Caritas SCSEP. "You" and "your" means the "Participant. The "property" is a Tablet owned by Caritas Family Solutions SCSEP with the following serial / assignment tag numbers:

This box is for Caritas SCSEP office use only. Place serial number/assignment tag number here.

- Terms:** You will comply at all times with this agreement, the Caritas Family Solutions SCSEP's Participant Handbook, and Acceptable Use Policy, incorporated herein by reference, and made a part hereof for all purposes. Any failure to comply may terminate your rights of possession effective immediately and Caritas SCSEP may repossess the property.
- Title:** Legal title to the property is in Caritas Family Solutions SCSEP and shall at all times remain in Caritas SCSEP. Your right of possession and use is limited to and conditioned upon your full and complete compliance with this Agreement and the Participant Handbook and Acceptable Use Policy.
- Loss or Damage:** If the property is deliberately damaged, lost, or stolen, you are responsible for the reasonable cost of repair or its fair market value on the date of loss. You must report loss or theft of the property to Caritas SCSEP by the next business day after the occurrence.
- A table of estimated pricing for a variety of repairs is included in the Acceptable Use Policy to which reference is hereby made. Participants must clear all records and pay all fees prior to exiting the program.
- Repossession:** If you do not fully comply with all terms of this Agreement and the Acceptable Use Policy in a timely manner, including the timely return of the property, Caritas SCSEP shall be entitled to declare you in default and may take steps to legally take possession of the property.
- Terms of Agreement:** You have the right to use and possess the property according to guidelines set forth by the Caritas Family Solutions SCSEP's Handbook and Acceptable Use Policy.
- Appropriation:** Your failure to return the property in a timely manner and the continued use of it for non-program purposes without Caritas SCSEP's consent may be considered unlawful appropriation of Caritas SCSEP's property.

**I have reviewed the Acceptable Use Policy Agreement and SCSEP Participant Handbook.**

You may download a copy of these documents from Caritas SCSEP website ([www.scsep@caritasfamily.org](http://www.scsep@caritasfamily.org)).

Participant Signature	Program Manager Signature	Date

White: Caritas SCSEP

Yellow: Participant  
Revised 10/15/2019

## **Caritas Family Solutions SCSEP Tablet Acceptable Use Policy**

I, \_\_\_\_\_, acknowledge receipt of the following company property from Caritas Family Solutions SCSEP for business use only:

Make:

Model:

Serial Number:

Unit Number:

☐ Power Supply Cord

☐ Carry Case

I understand that this property has been loaned to me and is the sole property of Caritas Family Solutions SCSEP. I am expected to exercise due care in my use of this property and to utilize such property only for authorized purposes. Negligence in the care and use will be considered cause for disciplinary action, which may result in discharge.

I also understand that the company property must be returned to Caritas Family Solutions SCSEP at the time of my separation from employment or when it is requested by my manager or supervisor and that I will be charged for any property issued and not returned to the Caritas Family Solutions SCSEP.

**Responsibility for Loss:** In the event the property is lost or stolen, the Participant will be billed the full cost of replacement. (\$50.00) **Actions Required in the Event of Damage or Loss:** Report the problem immediately to Caritas SCSEP

*[As a Note: Failure to return the device, power cord, carry case, and other accessories can result in the full charge of replacement. Any equipment not returned will be considered stolen property and will be reported to the local authorities.]*

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Program Manager Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## **Senior Community Service Employment Program Privacy Act Statement**

This statement applies to forms used by the Department of Labor for the Senior Community Service Employment Program (SCSEP) that contain confidential data collected from SCSEP applicants and participants. It also describes the collection of this information and how the information will be used.

The Privacy Act of 1974, as amended, requires all Federal agencies, including the Employment and Training Administration (ETA) and its agents, to give the following facts to each person from whom it requests information:

- The statutory authority for the request
- Why the information is needed
- Whether it is voluntary or mandatory to provide the information
- The effects of not providing information
- The uses which may be made of the information
- Whether disclosure of the Social Security Number (SSN) is mandatory or voluntary, by what statute or other authority the number is solicited, and what uses will be made of it

If you have any questions about your rights and responsibilities under the Privacy Act, you should ask for assistance from your SCSEP sponsor.

### **I. The Department of Labor's Authorization to Collect Information**

The Employment and Training Administration is an agency of the U.S. Department of Labor. The Department's authority to collect information from SCSEP applicants and participants is found in the Older Americans Act Amendments of 2006 (OAA Amendments), Pub. L 109-365, section 502(c)(4)(A)(ix). Data collection documents are approved under OMB clearance number 1205-0040, expiring 03/31/2015.

### **II. Why the information is needed**

The SCSEP needs information about age, citizenship, health, employability, behavior, family income, environment, and other matters related to your eligibility, assignment, and progress in the SCSEP. The information may be used to:

- Determine whether your training and employment needs can best be met through SCSEP or another program in your home community
- Determine whether you meet all eligibility requirements for the SCSEP
- Provide a basis for determining your progress in the SCSEP
- Maintain a record of wages and other benefits received

### **III. Obligatory and Voluntary Information and Possible Consequences of Withholding Information or Providing False Information**

While there are no penalties under the law for refusing to supply information, the SCSEP requires the collection and maintenance of a wide range of personal information about you, including your Social Security Number, to satisfy enrollment requirements. Not supplying the requested information could delay or prevent you from enrolling and participating in the SCSEP.

The provision of false information by you could lead to expulsion from the program or prosecution under the U.S. Criminal Code when such information is used to support a fraudulent claim to benefits.

### **IV. How the Information is used**

Your SSN will **not** be used as your SCSEP participant identification number. Rather, a separate number will be used on all SCSEP forms which require a unique identifier. In carrying out its responsibility under the OAA to administer the SCSEP program, the Department of Labor must sometimes disclose data from its records about you to another agency or individual without your specific written consent. Such disclosures may be made for the following reasons:

- To provide personnel, procurement, or benefit-related information to contractors and agencies to enable them to provide administrative functions for the program, including the maintenance of participant pay records
- Disclose to researchers and public interest groups those records that are relevant and necessary to evaluate the effectiveness of the overall program and its various training components in serving different subgroups of the eligible population
- To disclose information to the Office of Management and Budget in connection with its legislative review, coordination, and clearance activities
- To provide statistical information to the news media or members of the general public for the purpose of promoting the merits of the SCSEP
- To provide information to placement and welfare agencies, prospective employers, school, or training institutions to assist in participant employment
- To provide information to Federal, state, and local agencies and community-based organizations to facilitate statistical research, audit, and evaluation activities necessary to insure the success, integrity, and improvement of the SCSEP and other employment and training programs

In addition, if a person about whom records are maintained submits a written request to a Member of Congress or his or her staff, and that request is forwarded to the U.S. Department of Labor, we may release the information to the Member of Congress or Congressional staff in response to the inquiry made on behalf of the subject of the record.

### **V. A copy of this form must be given to each participant for personal reference upon enrollment.**