Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CareerSource Escarosa
Welfare Transition and Supplemental Nutrition Assistance Programs

OPERATIONS PROCEDURE MANUAL

July 1, 2021

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CHAPTER I

WT and SNAP Program Introduction

I. WELFARE TRANSITION (WT) AND SUPPLEMENTAL NUTRITION ASSISTANCE EMPLOYMENT AND TRAINING (SNAP E&T) PROGRAMS INTRODUCTION

A. General Approach

Welfare Transition (WT) and Supplemental Assistance Nutrition Program Employment and Training (SNAP E&T) are programs designed to move Temporary (Cash) Assistance for Needy Families (TANF) and SNAP Abled Bodied Adults Without Dependents recipients quickly from welfare to work. The purpose of these programs is to assist applicants and recipients in becoming self-sufficient by emphasizing work, self-sufficiency, and personal responsibility. This is accomplished by providing quality programs that includes both customer choice and progressive steps for a participant to achieve that will lead to his/her self-sufficiency. The end goal for each participant is to obtain full-time unsubsidized employment.

WT and SNAP participants are served through three One-Stop Centers located in Pensacola, Milton and Century, Florida. These centers provide: Formal Classroom Training, Resource Room Equipment, Computer Training, Job Skills Training, Job Search Opportunities, and Employment Assistance Workshops.

Community Work Experience and Internships at "for profit" businesses are also available for each WT and SNAP participant to complete as part of his/her steps leading to full-time employment.

CareerSource Escarosa has established as its highest priority a local system by which each customer is treated as an individual. Assigning activities will be based on work history, education and/or training, and current skills.

B. Oversight and Monitoring

The Department of Economic Opportunity (DEO) provides administrative and program guidance for workforce programs. Currently workforce, welfare, and employment services are delivered by the 24 Local Area Workforce Boards (LAWB) via the local One-Stop Centers.

CareerSource Escarosa serves as the Local Area Workforce Board for Escambia and Santa Rosa Counties as required by state law. All WT and SNAP programs and services are administered within LAWB 1 by CareerSource Escarosa. CareerSource Escarosa and its administrative staff serve as the administrative entity, grant recipient, and fiscal agent for the disbursement of grant funds within Escambia and Santa Rosa Counties. The Board of County Commissioners of both counties approve CareerSource Escarosa's five-year plan and has approval authority for the members that sit on the CareerSource Escarosa Board of Directors.

C. CareerSource Escarosa's Commitment to Values

1. Vision

Our region is recognized for its economic growth, driven by flourishing business and a skilled workforce.

2. Mission

We help businesses succeed by linking them to the workforce development resources they need.

3. Values

- **INTEGRITY**
  Our commitment to always do the right thing guides our decisions every day.

- **ACCOUNTABILITY**
  Each of us recognizes our responsibilities, and we use measures to show our success.

- **TEAMWORK**
  We work together with a variety of partners to achieve our mission.

- **DIVERSITY**
  We believe that diversity makes us stronger and we welcome those who challenge us to see things differently.

- **PROFESSIONALISM**
  We treat everyone with respect, courtesy, and personal attention.

- **LEADERSHIP**
  We lead by example with our organization and throughout the community.

- **INNOVATION**
  We continually seek new solutions and better ways to do our jobs.

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CHAPTER II

Initial Services

II. INITIAL SERVICES

A. INITIAL SERVICES

1. OVERVIEW OF WORK REGISTRATION

Work Registration begins with the applicant applying for cash or food assistance online with the Department of Children and Families (DCF) through the MY FLORIDA ACCESS System. DCF will complete all eligibility on all applicants to determine eligibility for TANF and SNAP. Once DCF determines the applicant is eligible, they will refer the applicant to the WT program or the ABAWD to the SNAP E&T program and inform them to access OSST Client online to complete the Florida State DEO Work Registration and/or Orientation.

Once the applicant completes the Online WR/Orientation, they are then directed to one of the below listed offices to complete additional WR requirements.

Escambia County Residents –
Monday - Friday 8:00 am to 3:30 pm
CareerSource Escarosa
Pensacola Career Center
6913 N. 9th Avenue
Pensacola, Florida 32504

Santa Rosa County Residents –
Monday Friday 8:00 am to 3:30 pm
CareerSource Escarosa
Milton Career Center
5725 Highway 90
Milton, Florida 32583

Century Area Residents –
Monday - Wednesday 8:00 am to 2:30 pm
CareerSource Escarosa
Century Career Center
7995 North Century Blvd.
Century, Florida 32535

2. WORK REGISTRATION ADDITIONAL STEPS

Once a TANF or SNAP participant is approved, an alert is received from DCF and the client receives a Notice of Mandatory Activity (NOMA) letter or a Notice of Mandatory Participation (NOMP) letter in the mail.

This letter directs the client to log back into OSST Client and complete their initial assessment and report to their nearest CareerSource Once Stop Center within 7 days. When the client reports to WT per their NOMA letter, WT Staff will check the skills development screen to determine if the client has completed their initial assessment. If not, the client will be directed to log back into OSST Client and complete it.

If the client is a SNAP participant, they will receive a Notice of Mandatory Participation (NOMP) Letter in the mail. The NOMP will direct SNAP participants to log into OSST Client and complete their online orientation and assessment then contact their local one stop center to schedule an appointment with their Career Advisor (CA).

Once an appointment is set, the WT/SNAP staff will enter that appointment in OSST and on the CA calendar and make the appropriate case note. During either process listed above, the WT/SNAP staff will also check the alternative plan screen in OSST to determine if the client has a sanction. If so, they will inform the client they need to complete a sanction lift packet and explain the entire process on how to fill it out and return it before the sanction can be lifted as complied. All OSST Client issues will be referred to the OSST Client help desk.

Once the client completes this process, the WT/SNAP Front desk staff will have each client complete the Grievance/Complaint form (Exhibit "A"), EEO Statement and Filing Procedures (Exhibit "B"), the Forgery Statement (Exhibit "C"). The WT/SNAP Staff then processes a childcare referral to Early Learning Coalition if applicable and schedule the participant their 1st Initial Career Advisor Appointment (utilizing the referral form for a Career Advisor Appointment (Exhibit "D") for the next available date and time on the Career Advisor's schedule. If the client is attending school or employed, they will be given a school enrollment verification form (Exhibit "E") or a verification of employment form (Exhibit "F") and inform the client to have it completed and bring to the initial career advisor appointment. Once all these actions have been completed, the NOMA in OSST can be closed as completed. For SNAP clients, these forms will be completed once they show up for their scheduled CA appointment.

1. If a WT client does not complete the process within the 7 days as instructed in the letter, OSST will automatically place a pre-penalty for WT client on their case and mail a pre-penalty letter to the client. The client then has 10 calendar days from the date the penalty letter is mailed to comply or provide good cause documentation to their assigned Career Advisor (CA).

2. If a SNAP client does not comply, DCF is notified via a sanction alert. They will then mail a Good Cause Notice letter to the client notifying them they have a 10 business day conciliation period to provide good cause to DCF for their reason of non-compliance. If good cause is not reported then DCF generates a Notice of Adverse Action (NOAA) and mails to the client for them to comply with the local workforce board along with the penalties that will be imposed on their case. See Chapter 5 of this manual for the sanction penalty process.

B. UP-FRONT DIVERSION

1. Up-Front Diversion assistance shall be provided to an applicant who does not need ongoing financial assistance; however, due to an unexpected circumstance or emergency situation, does require some immediate assistance to retain/obtain employment. Up-Front Diversion is cash assistance up to $1,000 in lieu of going on TANF. If the applicant is approved for Up-Front Diversion, he/she may not apply for TANF for a minimum of three months.

2. Up-Front Diversion is covered during the initial online Work Registration process. If the applicant selects Up-Front Diversion they are referred to their nearest CareerSource Center for an interview on the process. Once the Applicant reports to their nearest WT Office, they are given a Screening Form packet WTP-2073A Up-Front Diversion Form (Exhibit "G") and are immediately scheduled with the WT Manager (or in the absence of) their WT Career Advisor to interview, explain and determine eligibility and either approve or disapprove the upfront diversion request. If the request is approved the AUTO Work registration process is ended and the approved upfront is forwarded to the local DCF for processing. If the Upfront Diversion is disapproved, the applicant is instructed to complete the entire WR process for TANF.

3. Decisions are based on the emergency presented, the individual's circumstances, employment information, and whether Up-Front Diversion is in the best interest of the applicant. Emergencies that prevent a participant from starting work may include minor car repair, emergency child care, clothing, shoes, uniforms, and equipment for employment.

4. If approved, the Diversion Services Emergency Criteria - AWI 0001 Form (Exhibit "H") is completed and forwarded to DCF and a copy is retained in the case file. Payments should be authorized by DCF within five working days after receiving the authorization from the LAWB.

5. WT staff will record the Up-Front Diversion process in the state One-Stop Service Tracking (OSST) system under Service Plan on the Skill Development screen as "Up-Front Diversion Service". An Actual Start Date should be entered to indicate the date of the request for Up-Front Diversion services and a case note reflects the status of the application.

6. Determining a person eligible for Up-Front Diversion includes screening the individual to ensure:

    a. The individual documents his or her identity

    b. The individual provides information regarding household composition, diversion eligibility, and TANF eligibility

    c. The individual is an applicant and is not currently receiving Temporary Cash Assistance (TCA)

    d. The applicant has an emergency/unexpected situation that may be resolved through Up-Front Diversion;

    e. The applicant has secured an on-going means for meeting monthly recurring expenses

    f. The applicant is not currently sanctioned; sanctioned families are not eligible for Up-Front Diversion

    g. Employment verification or expected employment is submitted

7. If the applicant is not approved for Up-Front Diversion, the request is denied and the AWI 0001 should be completed and forwarded to DCF and a copy retained in the WT case file.

CHAPTER II
INITIAL SERVICES

EXHIBITS

- Exhibit “A” CareerSource Escarosa Grievance/Complaint Hearing/Appeal Procedures
- Exhibit “B” EEO Statement and Filing Procedures
- Exhibit “C” Forgery Statement
- Exhibit “D” Referral form for a Career Advisor appointment
- Exhibit “E” School Enrollment Form (if needed)
- Exhibit “F” Verification of Employment (if needed)
- Exhibit “G” – Up-Front Diversion Eligibility Screening Form
- Exhibit “H” – Diversion Services Emergency Criteria – AWI 0001 Form

Workforce Innovation and Opportunity Act (WIOA) Trade Adjustment Act (TAA), Welfare Transition (WT/TANF) and Wagner-Peyser (WP) Program participants and other interested parties (e.g., contractors, One-Stop partners, One-Stop operators, and employers) affected by decision or actions of the local workforce system have a right to file grievances/complaints with the local area Workforce Board. The grievance/complaint should be filed with CareerSource Escarosa, in accordance with the below listed procedures. In the event you submit a grievance/complaint not under the authority of CareerSource Escarosa, CareerSource Escarosa will notify you within 5 working days from the receipt of the grievance/complaint of the relevant agency responsible for the grievance/complaint.

Sexual Harassment Policy

An individual or entity desiring a copy of the CareerSource Escarosa Sexual Harassment Policy should write or call CareerSource Escarosa, 6913 N. 9th Ave., Pensacola, FL 32504; telephone number (850) 607-8752.

Criminal Fraud and Abuse

The procedures for reporting such incidents and instructions for completing the incident reporting form can be found at the following web site: http://www.floridajobs.org/forms/inspec_gen/complaint_assessment.doc. The form should be completed and mailed to: **USDOL Office of Inspector General**
Office of Investigations, Room S5514
200 Constitution Avenue NW, Washington, D.C. 20210
or to: **USDOL South East Regional Inspector General for Investigations**
Office of Investigations, Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 6T1,
Atlanta, Georgia 30303
Reports or complaints alleging fraud and abuse may also be reported through the USDOL Hotline at 1-800-347-3756.

Reporting Discrimination Complaints

Forms for filing discrimination complaints can be found at the following website:
http://www.floridajobs.org/civilrights/docs/Complaint%20form.docx

You may file a discrimination complaint by completing the Complaint Information Form found at the above referenced website or by sending information listed on form in writing as directed below:

WIOA/TAA complaints may be filed with CareerSource Escarosa's Equal Opportunity Officer or the U.S. Department of Labor's Civil Rights Center, with a copy mailed to the Department of Economic Opportunity and EEOC Tampa Area Office.

CareerSource Escarosa
Attn: Mrs. Janay Sims EOO
6913 N. 9th Ave.
Pensacola, FL 32504

or

U.S. Department of Labor
Civil Rights Center
200 Constitution Avenue, N.W., Room N-4123
Washington, DC 20210

Department of Economic Opportunity
Office for Civil Rights, MSC 150
107 East Madison Street,
Tallahassee, FL 32399-4129

and

Equal Employment Opportunity Commission (EEOC)
Tampa Area Office
501 East Polk Street, Suite 100
Tampa, FL 33602
813-228-2310 or TTY 813-228-2003

WT complaints may be filed with the U. S. Department of Health and Human Services, with a copy mailed to the Department of Economic Opportunity and EEOC Tampa Area Office (see addresses above). You can file electronically at the following address: civic.rights@deo.myflorida.com.

U. S. Department of Health and Human Services
Office of Civil Rights, Inspector General
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 3B70
Atlanta, GA 30303

WP complaints may be filed with the CareerSource Escarosa's Equal Opportunity Officer or the U.S. Department of Labor, Civic Rights Center (see addresses above).

You may contact **The Florida Commission on Human Relations, 4075 Esplanade Way, Room 110, Tallahassee, FL 32399, (850) 488-7082** to file a discrimination complaint within 365 days from date of the alleged violation.

Sight and speech impaired persons filing a complaint should call the Florida Relay System at 1-800-955-8771 (TTY) or 1-800-955-8770 for voice assistance.

Filing a Grievance/Complaint and request for Hearing/Appeal with CareerSource Escarosa

An **WIOA/TAA/WT** individual or entity, adversely affected by an CareerSource Escarosa action, to include but not limited to: displacement of employee; denial or termination as a **WIOA** training provider; denial of eligibility as a **WIOA OJT** or customized training provider; participant sanctioned for using controlled substances; termination of program eligibility or sanctioning for non-compliance with work activities, may submit a Grievance/Complaint or hearing request. Submissions should be concise and clearly written or typed; state the facts, laws, procedures, etc. that the grievant/complainant believes to be relevant for review; and must include a legible address where official notices may be mailed to the grievant/complainant.

For Hearing Request, include the words **REQUEST FOR A HEARING** at the top of the first page in capital letters; and specifically state the type of violation and nature of the action that is the subject of the grievance. The grievance shall be no longer than five pages (exhibits and attachments are not included in the five-page limit) and submitted to CareerSource Escarosa, Executive Director, 6913 N. 9th Ave., Pensacola, FL 32504. If possible CareerSource Escarosa will attempt to resolve the grievance/complaint informally. If the matter cannot be resolved informally, CareerSource Escarosa must establish a hearing date, complete the hearing and issue a decision within a 60-calendar day time frame from the date the grievance/complaint was filed. When the matter is not resolved informally, you will be notified by certified mail return receipt at least 15 calendar days prior to the hearing. The written hearing notice will include: hearing procedures, date, time, and place of the hearing; pertinent sections of the **WIOA, WT**, and any federal regulations involved. Affected parties may be represented at the hearing by an attorney or other representative, and may present witnesses or documentary evidence at the hearing. The parties will receive a written decision of the hearing within **30 calendar days** after the hearing by certified mail return receipt requested. Individuals alleging a labor standards violation may submit the grievance/complaint to binding arbitration procedure if the affected parties are covered by a collective bargaining agreement.

WP participants may file discrimination complaints against the Florida Department of Economic Opportunity (DEO) or its employees of complaints alleging discrimination by an employer. Special handling procedures are required for complaints filed by Migrant and Seasonal Farm Workers (MSFW). CareerSource Escarosa shall attempt to resolve the MSFW complaint. If the MSFW complaints cannot be resolved within five working days of receipt of complaint by CareerSource Escarosa, the complaint form and copies of all documents in the complaint file are forwarded to the Florida Department of Economic Opportunity (DEO), Monitor Advocate Office, MSC 150, 107 East Madison St, Tallahassee, FL 32399-4133. Attention: Senior Monitor Advocate.

***Note:** Individuals with a disability needing special accommodations shall call CareerSource Escarosa at (850) 607-8752 or fax at (850) 473-0935 at least five working days prior to the hearing and state what special accommodation requirements are needed in order to participate in the hearing.

Right to Appeal

An individual, or entity, adversely affected by CareerSource Escarosa actions or decisions can file an appeal with the State WIOA/TAA Administrative entity. An appeal may be made to the federal level (USDOL) if the state has not conducted a hearing or made a decision regarding the grievance/complaint **within the mandated 60-calendar day timeframe**, or if either party is dissatisfied with the state hearing decision. If the DEO Administrative Entity in conjunction with State Board staff determines that a grievance/complaint filed at the State level should have been decided at the local level, then the grievance/complaint may be remanded back to CareerSource Escarosa.

Filing a Grievance/Complaint and request for Hearing/Appeal at the State Level

Because of the many types of grievances/complaints and level of hearing/appeals allowed under WIOA/TAA/WT regulations, DEO staff working in conjunction with the State Board staff will be responsible for reviewing and determining the appropriate processing of requests/appeals filed at the State level. The following procedures should be followed when filing a grievance/complaint and/or requesting a hearing/appeal regarding a CareerSource Escarosa decision. The request and/or grievance /complaint for a hearing appeal should be clearly identified at top of the first page, i.e., REQUEST FOR HEARING. The written hearing request should not exceed five pages (not including attachments) and should state the facts, procedures, etc. that the grievant/complainant believes to be relevant for review and, if applicable, shall include any written decision made by CareerSource Escarosa and an address where official notices may be mailed to the grievant/complainant. The request shall be sent by certified mail return receipt to DEO, Office of General Counsel, MSC 150, 107 East Madison Street, Tallahassee, FL, 32399-4128. The grievant/complainant and CareerSource Escarosa will be contacted at least 5 working days of receipt of the complaint to attempt an informal resolution. If informal methods do not resolve the issue, then a hearing will be scheduled. The complainant/ grievant will be notified of the specific procedures for the hearing and will receive a decision within 60 calendar days from receipt.

State and Federal Level Appeal Process

If DEO has not reached a decision on the appeal of a local decision or the grievant disagrees with the decision, the grievant/complainant can file an appeal to USDOL no later than 60 calendar days of receipt of the decision being appealed. That request is submitted by certified mail, return receipt to Secretary USDOL, Attention: ASET, Washington, D.C. 20210. A copy of the appeal must be simultaneously provided to DEO (address above). Actions that may not be appealed to USDOL include: sanctions applied at the local level for using a controlled substance; sanction for non-compliance with work activities; or denial of eligibility as a WIOA/TAA training provider. WP states that non-ES related complaints (employment, discrimination, health and safety, etc.) must be forwarded as soon as possible after being received, to DEO, Office of General Counsel, MSC 150, 107 East Madison St, Tallahassee, FL, 32399-4128, or to the appropriate federal agency with a copy of the complaint sent to DEO Office of General Counsel. If the WP complaint is not resolved within 15 working days, then the complaint and associated file documents are forwarded to the DEO, Office of One-Stop and Program Support, MSC 105,107 East Madison St, Tallahassee FL 32399-4133, Attention: ES Complaint Coordinator.

I certify that I have read and understand my rights and responsibilities as enumerated above.

Participant/Service Provider/ Employee/ Employer or Other Signature & Date

As a representative of CareerSource Escarosa, I verify that the above-signed individual has read the Grievance Hearing/Appeal Procedures and has indicated an understanding of it.

CareerSource Escarosa Representative Signature & Date

Equal Opportunity Is the Law
(29 CFR 37.30)

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

- Against any individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief, and
- Against any beneficiary of programs financially assisted under Title I of the Workforce Innovation and Opportunity Act of 2014 (WIOA), on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his or her participation in any WIOA Title I – financially assisted program or activity.

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

- Deciding who will be admitted, or have access, to any WIOA Title I financially assisted program or activity;
- Providing opportunities in, or treating any person with regard to, such a program or activity; or
- Making employment decisions in administration of, or in connection with, such a program or activity.

What to Do If You Believe You Have Experienced Discrimination

If you think that you have been subjected to discrimination under a WIOA Title I – financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either CareerSource Escarosa's Equal Opportunity Officer or the U.S. Department of Labor's Civil Rights Center:

CareerSource Escarosa
Attn: Mrs. Janay Sims EOO
6913 N. 9th Ave.
Pensacola, FL 32505

or

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

Forms for filing discrimination complaints can be found at the following website:
http://www.floridajobs.org/civilrights/docs/Complaint%20form.docx

Send completed form (Complaint Information Form) or information listed on form in writing to the agency you wish to file your complaint.

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

If CareerSource Escarosa does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for them to issue that Notice before filing a complaint with CRC. However, you must file your CRC complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with CareerSource Escarosa).

If CareerSource Escarosa does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

You may contact **The Florida Commission on Human Relations, 4075 Esplanade Way, Room 110, Tallahassee, FL 32399, (850) 488-7082** to file a discrimination complaint within 365 days from date of the alleged violation.

I hereby acknowledge that I have read and received a copy of the Equal Opportunity Is the Law Notice.

_____ _____

Signature Date

To All Participants in the Welfare Transition Program

NAME: _____ RFA# _____

DATE: _____

You are participating in a Federal Workforce Program which is called the Welfare Transition Program. In order for you to receive TANF dollars, it is a requirement that you participate in activities 35-40 hours a week and that we received verified signed timesheets that you have completed these hours each week. These are not local requirements but federal requirements from the United States Congress in Washington D. C.

Forgery of signatures or any type of alteration of your hours on your time sheet by you is a serious offense. We take these offenses very seriously in this program and they will not be tolerated. The following actions will occur for the identified offense:

1. Forging signatures on any time sheets and/or altering hours on your time sheet -

    a. You will receive a sanction pre-penalty for the hours you missed. You will be given the 10-day period to present good cause.

    b. All support services will be cancelled during the sanction period. If you received gas cards, bus tickets, or any type of support services during that time of missed hours, your gas card/bus tickets will be suspended in the future when you are in good standing with the program for the same number of weeks that you received gas cards/bus tickets illegally.

    c. If you are assigned to an Internship or ETOP site you will be automatically transferred to another site when and if you become in good standing with the program.

2. Theft at the Center or at the worksite or school -

    a. The police will be called and charges will be made.

    b. You will receive an automatic sanction to your case in which your TANF benefit will be cancelled, and your childcare cancelled. A sanction may also affect your food stamps.

    c. If you are assigned to an Internship or ETOP site you will be automatically transferred to another site when and if you become in good standing with the program.

    d. All transportation and support services will be cancelled during the sanction period.

3. Being disrespectable in your language to any staff member or making any type of verbal threat to staff -

    a. You will receive one warning by a letter to you from the Welfare Transition Program Coordinator of CareerSource Escarosa.

    b. The next time it occurs you will receive an automatic sanction to your case in which your TANF benefit will be cancelled and your childcare cancelled. A sanction may also affect your food stamps.

    c. If you are in an Internship or ETOP site you may be transferred to another site.

    d. All transportation and support services will be cancelled during the sanction period.

By signing this form, I acknowledge the fact that this form has been explained to me and I fully understand the consequences

Participant's Signature	Print Name	Date

Escarosa Career Center/Program Staff Signature

Escarosa Career Center/Program Staff Name & Date

CareerSource ESCAROSA

REFERRAL FORM

NAME: _____

ADDRESS: _____ **RFA:** _____

_____ **DATE:** _____

As part of your participation in the Welfare Transition Program (WT) you have been scheduled to attend the following activity or appointment shown below:

CAREER ADVISOR

DATE: _____

TIME: _____

Career Advisor: _____

PHONE: _____

at the **CareerSource Escarosa, Welfare Transition office** located at **6913 N. 9th Ave., Pensacola, Florida 32504.**

THIS IS A REQUIRED WT ACTIVITY. **IF YOU FAIL TO PARTICIPATE OR FAIL TO COMPLETE THIS ASSIGNED ACTIVITY YOUR CASH ASSISTANCE GRANT AND FOOD STAMPS CAN BE TERMINATED.**

If for any reason you cannot keep this appointment, you must call the telephone number listed under your assignment BEFORE **the appointment time to discuss re-scheduling.**

THIS DOCUMENTATION CONTAINS CONFIDENTIAL INFORMATION AND IS PROTECTED BY LAW. IT IS INTENDED FOR USE BY AUTHORIZED USERS ONLY AND WILL BE KEPT AS A PART OF PARTICIPANT'S RECORDS. IT IS NOT FOR PUBLIC DISSEMINATION*

CareerSource ESCAROSA

Verification of School Enrollment

NAME: _____ Last 4 digits SS# _____

DATE: _____

In order to continue education as your primary activity, you must have the following information completed and returned to our office.

Educational Facility: _____

Program Title: _____

Length of Program: _____

Beginning Date: _____

Anticipated Completion Date: _____

School Official Signature: _____

Title: _____

Phone Number: _____

Date Completed: _____

_____

Participant Signature

Save | Save & Close | Rename | Cancel | Clear

VERIFICATION OF EMPLOYMENT/LOSS OF INCOME

NOTE: Use the "tab" key to move to the next field.

Date:_____

_____

_____

_____

In order to determine the eligibility of_____for public assistance, please assist us by answering the questions below and returning this form to us by_____.

_____
Case Name

_____
Case Number/Cat/Seq./SSN

Office Address / Phone Number:

Please complete each section which has been marked on Page 1 AND Page 2 of this form.

☐ **Section I – GENERAL INFORMATION**

1. Name of Employee:_____ Social Security Number:_____
   Address:_____
2. Job Title:_____ Type of Work Performed:_____
3. Number of Hours Worked Per Week:_____ Number of Days Worked Per Week:_____
4. A. How often is/was the employee paid? ☐ Day ☐ Week ☐ Bi-Weekly ☐ Monthly
   B. Rate of pay: $_____per_____. ☐ Other _____
   Hr./Day/Wk./etc. (Explain)
5. Date current employment began:_____ Date previously employed:_____
6. Does/did employee receive tips? ☐ Yes ☐ No ***(If yes, please show tips in Section III.)***
7. Is/was employment seasonal? ☐ Yes ☐ No If yes, season begins:_____ ends:_____
8. Is/was the employee covered by health insurance? ☐ Yes ☐ No
   If yes, name of insurance company:_____
9. Number of dependents covered:_____
10. Does/did the employee participate in any type of payroll savings plan or profit sharing? ☐ Yes ☐ No
    If yes, what is the balance? $_____
11. Does the person perform their job duties: ☐ in their home ☐ in your home ☐ N/A

☐ **Section II – LOSS OF INCOME**

1. Date employment ended:_____
2. Reason for termination:_____
3. Is the loss of income ☐ Permanent or ☐ Temporary? If temporary, when do you expect the employee to return to work? _____
4. Date employee received final check:_____ Gross amount: $_____
   (Please list last 4 weeks in Section III.)
5. Will employee receive any vacation pay, retirement refund, or other? ☐ Yes ☐ No
   If yes, what type? _____ Date received:_____ Amount: $_____
6. Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation, or other? ☐ Yes ☐ No If yes:
   A. Name of insurance company:_____
   B. Reason for benefits:_____

☐ **Section III – RECORD OF PAY RECEIVED**

List the gross amounts and dates of checks or cash, which were paid for the last four weeks in the space below.

Pay Period Ending	Date Pay Received	GROSS Earnings	No. of Regular Hours Worked	Rate of Pay	No. of Overtime Hours	Rate of Pay for Overtime	Tips $$	Earned Income Credit (EIC)

If hours or rate of pay has varied in the above period, please state why.

☐ **Section IV – EMPLOYER INFORMATION**

Go Back To Page One

What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.

Signature of Employer

Employer's Title

Name of Business

Telephone Number

If applicable, enter "ext." and extension number

Address

Date Completed

CF-ES 2620

Upfront Diversion Eligibility Screening Form

Applicant's Name (Please print legibly) * _____ **Last Four of SSN** _____

RFA Number _____ **Date Completed** _____

The purpose of upfront diversion is to provide help in finding a job or keep a job by assisting you in an emergency situation. Upfront diversion assistance requires recipients to remain off Temporary Aid to Needy Families (TANF) for three (3) months. Upfront diversion is a once in a lifetime assistance. Adhere to the following instructions: *Be advised that failure to complete this packet in its entirety will automatically disqualify you from being considered for the diversion.*

1. Complete the Upfront Diversion Screening Form.
2. Include verifiable copy(ies) of the emergency (car repair, past due bills, medical expenses, etc)
3. Complete the Emergency Statement and Budget.
4. Verifiable employment verification must be included in this packet.
5. Return the documentation to the WT Coordinator and/or Assistant Director for review.
6. Additional documentation may be required on a case-by-case basis for supervisor approval.

Official Use Only

Section A: TANF eligibility

1.	Is applicant TANF eligible?	(Yes)	(No)
2.	Does applicant understand, if approved, no support services are provided?	(Yes)	(No)
3.	Is applicant currently employed or has promise of employment?	(Yes)	(No)

If no to any of the above questions, client is not eligible for Upfront. If yes, proceed to the next section.

Section B: Upfront eligibility

1.	Has the applicant been approved for upfront in the past?	(Yes)	(No)
2.	Is the applicant in last three (3) months of TANF eligibility?	(Yes)	(No)
3.	Does the applicant have a poor work history?	(Yes)	(No)
4.	Due to ongoing TANF not authorized, will the applicant return to TANF within three (3) months?	(Yes)	(No)

If yes to any of the above questions, applicant is not an appropriate candidate for this diversion.

Employment verified (Yes) (No) (Date) _____

Upfront Approved (Date) _____ (Amount) _____

Up-Front Diversion/Relocation Screening Form

Applicant's Name (Please print legibly) * _____ **Last Four of SSN** _____

RFA Number _____ **Date Completed** _____

If you are applying for Temporary Cash Assistance, and you are employed or seeking employment, you may be considered for Up-Front Diversion or Relocation Assistance. Up-Front Diversion can help you find a job or keep the job you have now by assisting you with an emergency situation. If you qualify for Up-Front Diversion, you may also receive a one-time cash payment. The amount of this payment is limited but could be as much as $1,000. Relocation Assistance can help you find a job in another area, as well as relocate to an area to begin working. Both Up-Front Diversion and Relocation Assistance require recipients to remain off cash assistance for several months.

SECTION 1: To Be Completed by the Applicant

If you want to learn more about Up-Front Diversion or Relocation Assistance, please complete Section 1.

1. Do you have children in your care under the age of 19? ☐Yes ☐No
2. Is anyone in your household pregnant? ☐Yes ☐No
3. Are you currently employed? ☐Yes ☐No

   3b. If you are employed, when did you start your job?

   _____

   3c. If you are employed, where do you work?

   _____
4. Are you currently looking for a job? ☐Yes ☐No
5. What problems are you having finding or keeping a job?

   _____
6. How can this problem be solved?

   _____

   _____
7. If we can solve this problem, will it prevent you from applying for Temporary Cash Assistance? ☐Yes ☐No
8. How do you think we can help?

   _____

   _____
9. Are you facing a financial emergency or a situation that you were not expecting? ☐Yes ☐No

   Please explain:

   _____

   _____
10. What could help you overcome this emergency situation?

    _____

    _____
11. Who could verify your emergency situation? Name: _____

    Phone Number: _____ Other means of contact: _____
12. Would moving to another area help you? ☐Yes ☐No Please explain:

    _____

    _____

The information provided above is true and accurate to the best of my knowledge.

_____

Applicant's Printed Name

_____ ____/____/____

Applicant's Signature Date

An equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. All voice telephone numbers on this document may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711.

If applicant is potentially eligible for up-front diversion services, proceed to Section 2.

SECTION 2: Income Eligibility-To Be Completed By Workforce Staff

NOTE: **Should be completed based on the individual's statement of current family income.**

Step 1: Enter the number of family members applying for temporary cash assistance _____
DO NOT COUNT INDIVIDUALS RECEIVING SSI

Step 2: Enter the family's total monthly gross earned income _____
IF WAGES ARE WEEKLY, MULTIPLY BY 4.3 OR IF BI-WEEKLY MULTIPLY BY 2.15

Step 3: **Subtract the $90 standard earned income** disregard **for each family member with EARNED INCOME (1=$90, 2=$180, etc)** - _____

Step 4: **AMOUNT AFTER DEDUCTION** = _____

Step 5: **Add family's total monthly gross unearned income (examples: SSA, child support, unemployment/worker's compensation)**
DO NOT COUNT SSI + _____

Step 6: **TOTAL COUNTABLE INCOME** = _____

Step 7: Enter the **Payment Standard** for the family size identified in Step 1 from the chart below _____

Family Size	Payment Standard
1	180
2	241
3	303
4	364
5	426
6	487
7	549
8	610
Add a person to the family size	$62 per person

Is the amount entered in Step 6 less than the amount entered in Step 7? ☐ Yes ☐ No

If yes, the family is potentially eligible for Up-Front Diversion or Relocation Assistance (as a diversion)

If the individual is potentially eligible as indicated above, proceed to Section 3.

SECTION 3: Citizenship/Qualified Non-citizenship Status-To Be Completed By Workforce Staff

The family member served **MUST** be either a United States citizen or a qualified non-citizen. For assistance determining either status, please see Sections A, B and C:

____ **United States citizen**
____ **Qualified non-citizen**

If the individual is potentially eligible based on citizen/non-citizen status, proceed to Section 4.

SECTION 4: Attestation and Up-Front Diversion Agreement

PRIVACY ACT STATEMENT

_____**I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

_____*If I do not have a social security number and do not know how to apply for one, I understand that I can request help from the One-Stop Career Center or other program provider identified below.* The indicated person will refer me to the appropriate agency and may provide other help as needed and requested.

_____ I understand that my Social Security Number will be used to associate all records with my identification, including program participation and the receipt of services and benefits.

_____ I understand that by accepting either a one-time Up-Front Diversion payment of $ _____ (that will be placed on my EBT card). I am voluntarily declining to receive Temporary Cash Assistance (TCA) at this time. I understand that I, or any other member of my household, may not apply for TCA within the next three months, or before _____/_____/_____, unless I can show I have an emergency.

_____ I understand that if I **am not** potentially eligible for Up-Front Diversion payment as determined by the RWB provider, my application for Temporary Cash Assistance will be processed by DCF.

_____ I understand that if a demonstrated emergency forces me to apply for TCA before _____/_____/_____, I will have to pay back the diversion payment. The Up-Front Diversion payment I am receiving now will be divided over eight months and subtracted from any regular TCA benefits I might be eligible to receive.

_____ I understand that I may apply for Medicaid or Food Stamp benefits now or any time in the future.

_____ I understand that I can be approved for a diversion payment only once in my lifetime.

_____ I understand the receipt of Up-Front Diversion may allow me to receive childcare (TCC). This childcare will be to accept, maintain, or actively seek employment. I understand that applicant job search childcare will only be provided for 30-days from the start of the Up-Front Diversion process. I can only receive TCC if I obtain employment 90 days from the start of the Up-Front Diversion process. I must provide proof of my employment on a regular basis to get and keep my childcare.

_____ I certify that I have not received Up-Front Diversion payment in the past.

_____ I understand that the Up-Front Diversion payment and services are to provide assistance meeting the emergency and unexpected need so that I may get or keep my job.

By signing below, I _____ acknowledge that the information above is true. This includes information about my family, family's income, citizenship/qualified non-citizenship status and employment information. Failure to provide the correct information may result in a referral for fraud investigation. I understand that no support service will be authorized based on approval of this diversion. I also understand that I am not eligible to reapply for TANF for three months.

If my employment, income or demographic information changes (including phone number, address, family members in the home), I will report the information to both the Department of Children and Families and the One-Stop Career Center.

Print Name	Signature	Date
Address	City/Zip Code	Phone Number
RWB Provider	Signature	Date

One-Stop Career Center Address: 6913 N. 9th Ave.
Pensacola FL 32504

Phone Number: (850)607-8800

EMERGENCY STATEMENT AND BUDGET

Participant Name: _____ Social: _____

Please give a brief statement explaining your financial emergency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

BUDGET WORKSHEET

Estimate costs for at least one month:	Type		Name of Company/ Explanation of Cost
Housing Expenses	Rent	$	
Transfer fees/deposits:	Electric	$	
	Telephone	$	
	Gas	$	
	Cable	$	
	Water	$	
	Food	$	
Other:		$	
	TOTAL ESTIMATED EXPENSES:	$	

Diversion Services Emergency Criteria

***Section A**: To be completed by the Regional Workforce Board*

Individual's Name (please print) *Social Security Number

Case #/Category/Sequence (if available) Date

The individual above ☐ has ☐ has not met emergency criteria for the following program:

☐ Up-front Diversion ☐ Relocation ☐ Cash Assistance Severance Benefit

If the individual met emergency criteria for relocation, was the individual a victim of domestic violence? ☐ Yes ☐ No

The individual is ☐ eligible ☐ not eligible to reapply for temporary cash assistance.

Comments:

_____

Regional Workforce Board Designee (please print) Telephone Number

***Section B**: To be completed by the Public Assistance Specialist*

☐ **Up-Front Diversion** – the individual received an up-front diversion payment on _____/_____/_____ for $_____. If the reapplication is within three months from this date, the diversion payment shall be prorated over an 8-month period and deducted from any temporary cash assistance for which the family is eligible.

☐ **Relocation Assistance** – the individual received a relocation payment on _____/_____/_____ for $_____. Other than domestic violence, if the reapplication is within six months from this date, the repayment must be made on a prorated basis and subtracted from any regular payment of temporary cash assistance for which the applicant may be eligible.

☐ **Cash Assistance Severance Benefit** - the individual received a cash assistance severance payment on _____/_____/_____ for $1,000. If the reapplication is within six months from this date, the $1,000 payment shall be prorated over an 8-month period and deducted from any cash assistance for which the family subsequently is approved.

_____ _____/_____/_____

Public Assistance Specialist's Signature Date

PRIVACY ACT STATMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a Social Security Number and have not applied for a social security number, I can request help with filing an application. The Social Security Number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CHAPTER III

Approved Work Activities

III. APPROVED WORK ACTIVITES FOR MANDATORY PARTICIPANTS

After a participant has completed the Work Registration and/or Orientation process and their case is opened in mandatory status, he/she will receive an initial appointment with his/her WT/SNAP Career Advisor. Then, the Individual Responsibility Plan (IRP) is completed and participants are assigned to activities. The Department of Children and Families (DCF) notifies the WT/SNAP Career Advisor (CA) via electronic alert of the participant's "mandatory" status.

The purpose of case management is to provide individual guidance and progressive steps that lead each participant toward economic self-sufficiency.

A. WT Activities

The Florida State Work Verification Plan defines the required activities as "Core Activities" and "Core Plus Activities" for WT participants.

1. <u>Core Activities</u>

Core Activities are required work activities that can stand alone or in conjunction with another Core or Core Plus Activity for the participant to meet required hours.

a. Job Search and Job Readiness

All internal Job Search activities are supervised by CareerSource Escarosa staff. The WT weekly activity time sheets (Exhibit "A") are given to participants and each activity must be signed by a staff member in order to validate hours. Electronic timesheets in lieu of the paper timesheets may also be used to record activity hours. For those participants assigned to an activity not at CareerSource Escarosa, their timesheets shall be signed by the supervisor, teacher etc.

Time sheets must be submitted by either the participant or the work site and must be submitted on time. The submission of all timesheets is the participant's responsibility.

WT has established the following activities as part of Job Search and Job Readiness.

i. CareerSource Escarosa Workshops: These workshops are developed and taught by local staff on site that assist the participant in obtaining basic computer knowledge, navigating Employ Florida, resume classes, interviewing skills, customer service skills etc.

ii. Internal Job Search: This is a job search done on the computers at one of the Escarosa One-Stop Centers.

iii. External Job Search: External Job Search hours are those spent by a participant completing job search outside of the center or actually traveling to businesses to either "cold-call", complete applications or attend job interviews.

b. Employment and Training Opportunity Program (ETOP)

Community Work Experience in LAWB I is known as Employment Training Opportunity Placement (ETOP).
ETOP is a structured program in which Temporary Cash Assistance (TCA) work-eligible recipients perform work for the direct benefit of the community, under the auspices of non-profit or for-profit organizations. ETOP consists of both non-profit work experience and Internships at for-profit businesses.

c. Non-Profit Work Experience and Internships

Non-Profit Work Experience is structured and supervised work in exchange for benefits for individuals who lack experience in the workplace. The work experience will enhance participant skills and experience in the workplace.

For both ETOP and work experience/internships, participants may have an employee evaluation completed on them by the worksite supervisor after 30 days if needed. This evaluation will be utilized by the participants CA to counsel the participant on their deficiencies and strengths.

d. Unsubsidized/Subsidized (Public or Private) Employment

Unsubsidized/Subsidized Employment is when the participant works in the private or public sector for pay. If the participant is employed a minimum of 35 hours per week at minimum wage or higher, it can be used as his/her only activity. In the case of a participant who is working as wait staff and receiving tips, the wages will be calculated at the regular minimum wage.

If employed less than 35 hours per week or if the participant is working for less than minimum wage, the participant must be involved in additional approved work activities.

e. On-the-Job Training (OJT)

On-the-Job Training is paid employment provided by a public or private employer through a contractual arrangement in which the employer provides training and skills essential to perform the job, and CareerSource Escarosa reimburses the employer to offset the cost associated with training. OJT is full-time or part-time employment. A CareerSource Escarosa Business Services Representative will coordinate all OJT agreements. This activity is subject to available funding.

f. Vocational Education and Training

Vocational Education and Training prepares an individual for employment through organized and approved training in Florida's vocational technical centers, community colleges, universities or propriety schools. Under this activity, participants gain knowledge in a specific occupation and become economically self-sufficient and exit the Welfare Transition Program. See Chapter V of this manual for all eligibility requirements and procedures.

g. Providing Child Care Services

Region 1 does not utilize this activity to count as hours however the client may operate a licensed day care (in home or not) as a personal business. This is classified as Self Employment under Unsubsidized Employment in the State's Work Verification Plan. To earn participation credit for hours of self-employment, a participant must provide documentation that details gross income minus business expenditures. Self-attestation is not acceptable as documentation. For self-employed individuals, Florida will report participation based on the number of hours that result from dividing the gross income minus business expenses (as verified by the documentation presented) by the minimum wage.

In addition, all participants must meet all requirements and eligibility to be licensed with the Department of Children and Families and Early Learning Coalition.

2. Core Plus Activities

Core Plus Activities are supplemental work activities that have an educational or training aspect and **must be accompanied by a**

minimum number of hours of participation in a core activity to count towards participation.

a. Job Skills Training Directly Related to Employment

Job Skills Training Directly Related to Employment is a work activity that includes both education and training for job skills required by an employer in order to provide a participant with the ability to obtain/maintain employment. This includes customized training to meet the needs of a specific employer or it can be general training that prepares a participant for employment. For this activity, the participant must possess either a High School Diploma or GED.

Job Skills Training may also be assigned at the participants ETOP site provided a separate training plan is completed. The assigned job skills outlined on the approved Training Plan **MUST** be different than those assigned to the participant for ETOP. Other activities may include, but are not limited to, the following activities:

- On-Site and Off-Site Approved Workshops
- General Training
- On-Line Tutorials (i.e., Florida Ready to Work, Alison.com, etc.)
- CareerScope Assessment
- Virtual Learning Center (VLC)
- Mavis Beacon Typing
- AZTEC Training
- Classroom Instruction

b. Education Directly Related to Employment

Education Directly Related to Employment is for participants, regardless of age, who do not have a high school diploma or

GED and need further education and training related to a specific occupation, job or job offer.

Participants can attend motivational and/or soft skills workshops and/or receive general training at the job skills training computer lab. WT allows for this activity to be separated into the two distinct components which may include, but are not limited to, the following activities:

c. Satisfactory Attendance at a Secondary School or a Course of Study Leading to a GED only allows for the completion of a GED. WT allows for the completion of this requirement by attending an off-site class at a state-recognized program.

3. <u>Medical Deferrals</u>

A Participant who has medical limitations and will be unable to complete the required amount of participation hours must identify these limitations to their Career Advisor. The Career Advisor will send a Medical Verification Form (MVF) AWI-WTP 2288(a) (Exhibit "B") along with a cover letter to the participants physician of choice to be completed. but must be completed by a <u>licensed physician (ME or DO) or an Advanced Clinical Nurse (ACN).</u> In the absence of the medical verification form, a medical statement signed by a licensed physician or ACN as mentioned above will be accepted.

CareerSource Escarosa will accept any form of documentation that clearly documents the individual's medical incapacity and limitations signed only by Physicians and ACN's who are licensed in accordance with Florida Statutes Chapter 458 or 459. All Local Operating Procedures (LOP) must adhere to State Policy and the Medical Incapacity Guidance.

a. During the initial CA appointment, the CA will determine what

activity(ies) if any, the applicant can complete based upon limitations stipulated by the physician. This decision will depend upon the number of hours that the applicant is allowed to work, as well as the physical limitations reported on the MVF.

b. The CA will conduct a verbal and written assessment and the information collected will be used to create an Alternative Responsibility Plan (ARP) and Steps to Self-Sufficiency (SS). The ARP will include, but is not limited to: participation, medical appointments, follow-up appointments and possibly Vocational Rehabilitation along with Steps to Self Sufficiency. If a participant refuses to sign the steps to SS. The CA may write in the "participant refused to sign" then sign the steps along with a second CA as a witness.

c. During the initial appointment, the CA will counsel the participant and determine appropriate activities for him/her. The participant's documented medical condition and the number of hours allowed to work will help determine what activities are assigned. The participant will be required to complete the number of hours documented by the licensed physician or ACN. Under no circumstances will the participant be assigned more hours than that documented by the licensed Physician or ACN.

d. All medical participants will be required to contact their CA to update any change in medical condition, treatment plan, Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Depending upon the severity of the medical condition, contact may be made by phone or regularly scheduled appointment.

e. Each medically limited participant must have a new MVF or documentation detailing the participant's limited abilities or inabilities every 3 months to remain medically deferred. If the participant is unable to have a new MVF updated by the medical

provider, the participant will be assigned to regular activities or will be subject to sanction.

f. All participants who have applied for SSI/SSDI must submit documentation verifying the application. SSI/SSDI applicants may be excused from regular work activities. These participants will be required to comply with an ARP with assignment based upon the Doctor's recommendation on the medical deferral.

If the participant submits a medical statement signed by a licensed physician under the Florida Statue 458 or 459, it can be accepted. If the participant is mandatory, the CA will place the participant under a temporary (deferred other) for 10 days until the MVF can be submitted.

g. Other Deferrals

A WT Career Advisor may assign the participant to a Deferral Status. Deferral is simply defined as an extenuating circumstance that does not allow the participant to complete work activity. A deferral from work activity can also be made if the participant falls into one of the following categories:

- Lack of Childcare: When suitable childcare is not available in the immediate geographic area or for some unforeseen reason, the childcare provider is unable to provide childcare (i.e., hospitalization, illness, etc.), WT may place the Participant under a temporary deferral from work activity.

- Lack of Transportation: A participant who is unable to complete a work activity due to excessive cost of transportation may be temporarily deferred. This cost would have to exceed $50.00 per day in travel expenses. In these cases, the CA will talk with the participant regarding possible relocation assistance to an area where the participant can find

employment. If a deferral is made, it may not exceed thirty (30) days.

- Natural Disasters: A participant may be temporarily deferred when he/she is unable to complete a work activity due to the State declaring a "State of Emergency" for the area due to a hurricane, tornado, flooding, or other natural disaster.

- Deferral Due to Other Reasons: A participant who is unable to complete the required work activity due to special circumstances may be granted a temporary deferral from work requirements.

- Domestic Violence (DV): A participant who is a victim of Domestic Violence may be deferred from work activities, but an alternative plan must be completed. See Chapter 6 of this manual for further guidance.

B. SNAP E&T

1. Florida's SNAP E&T is a mandatory program designed to help Abel-bodies Adults Without Dependents (ABAWD's) gain skills, training, and/or work experience that will increase their ability to move directly into employment. An ABAWD is an individual who is between 18-49, does not have dependents, and does not meet an exemption outlined in 7 Code of Federal Regulations (CFR) 273.7(b) or and ABAWD exception outlined in 7 CFR 273.24(c).

2. Activities

   a. Job Search – provides ABAWD's with meaningful assistance to seek employment and improve his/her ability to get a job. Job search activities include online or in person submission of applications or resume', in person, web-based or phone

interviews, attendance at job fairs or recruiting events and other opportunities that assist the ABAWD with activity seeking employment. ABAWD's may only be assigned to job search for up to 39 hours per month, which is less than half of the 80 hour per month ABAWD work requirement. When job search and job search training are combined, the total hours assigned cannot exceed 39 hours. Job search must be combined with other allowable activities to achieve 80 hours per month.

b. Job Search Training -provides training activities to assist in the development of essential employment skills for the ABAWD to secure and retain employment. Job search training activities may be conducted directly in the Career Center or through community partners. Job search training may include, but not limited to, workshops that address life skills, time management, soft skills, interpersonal skills, decision making, job seeking skills, job retention skills, appropriate dress for the workplace and career planning. Like job search, job search training hours are limited to 39 or less hours per month and may be combined with other allowable activities to achieve 80 hours per month.

c. Basic Education -Allowable education activities may include, but are not limited to,

    - Adult basic education
    - Remedial education
    - High school completion or GED
    - Post-secondary education
    - English for speakers of other languages (ESOL)

    ABAWD's assigned to this activity may be allowed one hour of study time for each hour of class time completed, if verification is provided of the actual time spent in the classroom.
    SNAP E&T funds may be used (if funding permits) if federal funds are not used or the ABAWD cannot obtain federal

assistance such as Pell Grant or the ABAWD was not eligible for the funds.

d. Vocational Training – Provides an opportunity for ABAWD's to participate in specific training to gain knowledge, skills and competencies required for particular occupations or trades. This activity may be combined with job search or job search training or other qualifying components to achieve the required 80 hours per month.

   ABAWD's assigned to this activity may be allowed one hour of study time for each hour of class time completed, if verification is provided of the actual time spent in the classroom.

   SNAP E&T funds may be used (if funding permits) if federal funds are not used or the ABAWD cannot obtain federal assistance such as Pell Grant or the ABAWD was not eligible for the funds.

e. Work Experience -Connects ABAWD's with employers to build job related skills through practical experience to obtain employment. This activity may be combined with job search, job search training or another qualifying component.

   If an ABAWD is assigned to a worksite, a worksite agreement must be completed and agreed upon by both CareerSource and the employer before the ABAWD may start their work experience. The calculation used to determine the required hours of work experience participation is the household's food assistance allotment divided by the higher of the federal or state minimum wage. The result is further divided by the number of individuals in the food assistance group. **An individual cannot be required to complete more hours at a worksite during the month of participation than the benefit calculation allows.**

3. Exemption / Exception - If an ABAWD is unable to participate in any required activity component, the ABAWD MUST contact DCF to inform them as to the reason why. DCF may grant an exemption or exception to the client. If documentation is needed, the Career Advisor will obtain the appropriate documents such as a medical deferral or other documentation form the physician, SAMH documentation, Employment verification, proof of school enrollment etc.

CHAPTER III
APPROVED WORK ACTIVITIES

EXHIBITS

- Exhibit “A” – WT/SNAP Weekly Activity Time Sheets (2 pages)
- Exhibit “B” – Medical Verification Form AWI-WTP 2288(a) (3 pages)

WT/SNAP Weekly Activities Time Sheet

Name: _____ Last 4 SSN#: _____ Career Advisor: _____

Week Of: _____ Employment YES or NO: _____ Hourly Wage:_____

I understand that CareerSource Escarosa is intended to educate and assist individuals in the attainment of employment. Submitting this form to the WT/SNAP program office is an affirmation that the following activities have been completed. I must continue with these activities each weekday until I am directed not to do so by my Career Advisor. I must follow through on job leads and work with CareerSource Escarosa staff to improve my opportunities of finding a job. This timesheet must be submitted to CareerSource Escarosa by 1:00pm each Monday.

Fax: Pensacola (850) 607-8851 – Milton (850) 983-5330 – Century (850) 366-4015

Date	Type of Activity or Name of Class	Time In:	Time Out:	Time In:	Time Out:	Total Hrs: (completed by WT/SNAP Staff Only)	Supervisor or Instructor Signature:

(For WT/SNAP Use Only)

For Official Use Only:	JPR Week Being Verified:		Hours Credited:		Career Advisor Signature:	

Participant Signature: _____ Date: _____

WT/SNAP External Job Search Log

Name: _____ Last 4 SSN#: _____ Career Advisor: _____

Submitting this form to the WT/SNAP program office is an affirmation that an active job search to the following employers has been completed. You will receive 1 hour of job search credit for each completely filled out contact.

***PLEASE PRINT in BLUE OR BLACK INK* This Job Search will be randomly verified and must be completed with a pen.**

Date of Job Search:____/____/____			
	Business Name	**Street Address or Website**	**Position**
1			
2			
3			
4			
5			
6			
7			

(For WT/SNAP Use Only)

For Official Use Only:	JPR Week Being Verified:		Hours Credited:		Career Advisor Signature:	

Participant Signature: _____ Date of Submission: _____

_____ _____

Name of Physician Date

Dear Physician,

I, _____, am requesting that the attached Medical Verification form be completed.

In order to receive temporary cash assistance and prepare individuals and families for self-sufficiency, individuals receiving cash assistance are required to participate in countable work activities. Additionally, Florida limits such families to receive cash assistance for a total of 48 months. Some participants may receive a medical deferral as a result of an injury, a temporary medical condition, or other good cause reason. However, if a participant is in deferred status, he/she continues to be subject to the cash assistance time limits.

- I am requesting that my medical information be released to the Welfare Transition Program provider to help me develop my self-sufficiency plan. To become self-sufficient, I will work with my career manager to overcome barriers to employment and/or seek medical/disability services.
- My self-sufficiency plan may include participation in medical treatment, counseling, therapy, etc.
- My plan may include employment, attending classes, studying at home, or volunteering at a worksite designed to meet my physical/mental health limitations.
- Each time a new form is needed, *I will sign a request for medical information authorizing the licensed physician to complete the form.*
- The participant or legal guardian for participants under the age of 18 are the only representatives allowed to provide consent/request for information on the medical verification form.
- **The release of medical information portion of the medical verification form is located on the next page.** The release of medical information verifies that I have reviewed my rights and responsibilities regarding the release of my confidential health information with my career manager. **The release includes my rights and responsibilities as stated in the Health Insurance Portability and Accountability Act (HIPAA).**

Thank you for taking the time to complete the medical verification form. Please forward the completed form to my career manager at the below address/fax number. If you prefer, you can release the paperwork back to me, and I can deliver the paperwork myself.

Name: **Phone Number:**
Address: **Fax Number:**

Release of Medical Information

Participant's Name: **Social Security Number:**

Birth date:

I understand that I have given the physician permission to complete the medical verification form.

- I understand that the information will state my current diagnosis and possible limitations to engage in countable work activities. By completing the medical form, I am requesting that my physician provide the information to the Welfare Transition Program (WTP) provider.
- The information on the form will be used to develop a personalized self-sufficiency plan that takes my limitations, medical needs and treatment into consideration. The completed form may also be used when considering an extension to my cash assistance time limits.

Rights

- I have the right to refuse to sign the Release of Medical Information Form. Refusing to sign the form (**alone**) will not affect my benefits.
- The authorization of the Medical Verification Form may not condition medical treatment, payment, or enrollment.
- I understand that I have the right to revoke the authorization of this form. To revoke the authorization, **I must submit a request in writing to both the physician and the WTP provider. I will have to provide the written request to both parties by the close of business (5 p.m.) on _____/_____/_____.**
- Once the form is completed, the form will be included in my case file, but the information may not be used to determine limitations or medical inability after six months from the physician's signature date.
- I have the right to privacy. The medical verification form and information that is given in the form is confidential health information. The WTP provider is the sole recipient of the information. The information may be disclosed only in the course of official business and the verification of continued eligibility/compliance.

Responsibilities

- I have agreed to have the form completed and return the completed form to my career manager by (*date*)_____ at (*time*)_____.
- **If I refuse to sign the form or fail to supply the required information by the above date**, I **must** participate in the Welfare Transition Program's (WTP) countable activities for the minimum required hours unless another good cause reason is documented.
- I **must** complete the activities as indicated on my self-sufficiency plan. **Refusal to sign the form and failure to participate in countable activities may result in the reduction or cancellation of my cash assistance and food assistance benefits.**
- **If I refuse to participate in the program and fail to complete the agreed upon activities listed in my self-sufficiency plan, my benefits may be reduced or cancelled.**
- If the form is revoked, I am still responsible for completing the activities I agreed to complete on my self-sufficiency plan.

I have reviewed my rights and responsibilities with my career manager.

_____ _____ Expiration of Request is 60 days from signature date.

Signature of Participant Date of Signature

_____ _____ _____

Signature of Guardian if under 18 years of age Printed Name of Guardian Date

MEDICAL VERIFICATION FORM TO BE COMPLETED BY LISCENSED PHYSICIAN

Name of Participant: **Social Security Number:**

1. What is the specific diagnosis of illness/injury of the participant? _____

2. A participant **may still be able to work** with limitations **or be assigned to an activity** that requires little physical strain or demand (attending classes, volunteer, home study, answering telephones, filing while seated).

WORK

a) Can (s)he "work" sitting down? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted _____

b) Can (s)he "work" standing up? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted _____

c) Are there other restrictions to him/her working? ☐ Yes ☐ No

Restrictions: _____

d) Are the number of hours (s)he can "work" limited? ☐ Yes ☐ No

☐ 1-10 hours ☐ 11-20 hours ☐ 21-30 hours ☐ 31-40 hours a week **or** ☐ Unable to "work" at all

VOLUNTEER

e) Can the (s)he volunteer hours? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted _____

Other limitations: _____

SCHOOL

f) Can the (s)he go to school or go to classes? ☐ Yes ☐ No Comments:_____

Are there limitations? _____

3. Is this condition ☐ permanent or ☐ temporary? If temporary, indicate estimated duration _____# Months. If this individual is pregnant, what is the expected date of delivery? _____/_____/_____.

4. Is (s)he required to attend physical therapy? ☐ Yes ☐ No If yes, how often? _____

5. Is (s)he required to attend counseling appointments? ☐ Yes ☐ No If yes, how often? _____

6. Is (s)he required to attend any other type of therapy or regular appointments? ☐ Yes ☐ No If yes, how often? _____

7. Date of patient's most recent office visit: _____/_____/___

_____ _____ (____) ____-_____

Name of Licensed Physician **Signature of Physician: this form must be signed by a *Licensed* Physician.** **Telephone Number**

_____

Mailing Address (include city and zip code)

_____ _____/_____/_____

Physician's License Number (per Chapter 458 or Chapter 459, F.S.) **Date Form Completed**

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

DEO-WTP 2288(a), March 2013 (Replaces DEO-WTP 2288(a), October 2011)
Includes HIPPA language and requirements

Careersourceescarosa.com
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CHAPTER IV

Employment and Training Opportunity Program (ETOP)

IV. EMPLOYMENT AND TRAINING OPPORTUNITY PROGRAM (ETOP)

A. ETOP Overview

ETOP is job training at a supervised public/private non-profit agency and for-profit employers. Local Area Workforce Board (LAWB) I has developed a two-tiered system, non-profit work experience and Internship. Both non-profit work experience and Internship allow Welfare Transition (WT) and Supplemental Nutrition Assistance (SNAP) program participants to learn and practice basic employment skills such as punctuality, regular attendance, getting along with peers and co-workers, following directions, and learning to coordinate work and family obligations.

While participating with non-profit work experience/Internship activities, the WT/SNAP participant will:

1. Continue to receive the total amount of his/her authorized Temporary Assistance for Needy Families (TANF) and/or SNAP Assistance in lieu of a wage.

2. Be deemed an "Employee of the State" for purposes of Worker's Compensation coverage and be subject to the requirements of drug-free workplaces.

3. Complete a required assigned number of hours of ETOP (the formula for participant hours is covered in Chapter 5 of this manual). A participant in ETOP may also be assigned to additional activities to ensure all required hours are completed.

B. Employment Training Opportunity and Placement Procedures for WT and SNAP Participants

1. In Escambia and Santa Rosa Counties, the Business Services Representatives (BSR's) for CareerSource Escarosa will be responsible for communicating with area employers on the opportunity of the ETOP Program. If an employer is interested the BSR will provide an orientation brief about the two programs. If the employer desires to enroll, the BSR will sign them up as an ETOP site by completing a Memorandum of Understanding (Exhibit "A") and Worksite Signature Card (Exhibit "B") for approving time sheets.

2. During a CA appointment, the CA will issue the participant with a CareerSource Escacrosa Work Experience Referral (Exhibit "C") and a list of approved worksites. The participant will call and/or visit only the approved worksites to speak with the appropriate supervisor about signing up for work experience and possible employment. The supervisor will conduct and interview to approve or disapprove of the participant. If approved, the supervisor will complete the form assigning scheduled days and hours then sign and date the referral. If disapproved, the participant must continue to contact approved worksites for work assignment until he/she finds a match. Once the participant obtains a worksite, they will return the form at their CA follow up appointment for ETOP assignment.

3. The participant will remain in Job search until his/her ETOP activity begins provided it does not exceed the four-week limitation for job search.

4. During the follow up for the ETOP assignment, the CA will place a copy of the Work Experience Referral, ETOP Requirement Form (Exhibit "D") in the case file. The Work Site Training Outline will be completed (Exhibit "E) and if needed a Worksite Job Skills Training

(JST) Outline (Exhibit "F") along with the Failure and Re-imbursement form (Exhibit "G") and placed in the participant's folder. The participant and the worksite supervisor will both receive a copy of the Training Outlines and the Emergency Contact Form (Exhibit "H").

Participants will be instructed that if he/she is late for work or misses work for any reason, he/she must call his/her Site Supervisor and CA prior to their scheduled work shift. His/her CA may determine "good cause". If a participant misses work and does not make up his/her hours, they must contact their Career Advisor (CA) to determine good cause.

5. Based upon where the participant is assigned for work, the CA will determine if the participant will use the WT/SNAP weekly activities time sheet or submit electronic timesheets. Participant work hours must be submitted to the appropriate Escarosa Center utilizing the WT/SNAP Weekly Activities Timesheet (Exhibit "I") that they are participating with and is the sole responsibility of the participant.

6. The CA is responsible for updating all participant folders and case notes for all events and contacts.

7. The CA will monitor each participant's work performance and the job sites for ETOP Program adherence. The CA will perform the following procedures:

a. After a WT or SNAP participant has been assigned to a work site, the CA will call to ensure compliance.

b. The work site supervisor will complete a Client Evaluation Form (Exhibit "J") by phone call, mail or fax. The CA will review it with the participant.

CHAPTER IV

EMPLOYMENT AND TRAINING OPPORTUNITY PROGRAM (ETOP) EXHIBITS

- Exhibit “A” – Memorandum of Understanding
- Exhibit “B” – Worksite Signature Card
- Exhibit “C” – Work Experience Referral
- Exhibit “D” ETOP Requirement Form
- Exhibit “E” – Work Site Training Outline
- Exhibit “F” – Worksite Job Skills Training (JST) Outline
- Exhibit “G” Failure and Re-Imbursement Letter
- Exhibit “H” Emergency Contact Form
- Exhibit “I” WT/SNAP Weekly Activities Timesheet
- Exhibit “J” – Client Evaluation Form
-

EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM FOR WT AND SNAP WORK EXPERIENCE

THIS MEMORANDUM OF UNDERSTANDING OF EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM (ETOP) is entered between **CareerSource Escarosa,** hereafter referred to as "Escarosa", and Vick's Cleaners hereafter referred to as "The Business".
THE PURPOSE of this Memorandum of Understanding is to provide your business with one or two program participants to work from 1-90 days. As an eligible ETOP site you agree to the following:

- Employs 5 or more paid employees (if less than 5, special approval has been given by the WT/SNAP Program Manager)
- Has a current business license
- Is a non-residential based business

This will be a non-paid job-training experience for the individuals in our ETOP program. Your business will have the option of returning any program participant at any time within the assigned period if he/she does not meet your standards. If the participant successfully completes your training program, it is our hope that you will hire him/her as a full-time employee, but this is not a requirement.

Escarosa Agrees to:

- Refer eligible program participants to the business for consideration in the work experience component.
- Provide child care, transportation, and other work-related expenses as needed for the trainee to the extent funds are available, and the expense is authorized by law or regulation; and
- Worker's compensation liability and/or claims coverage (but NOT benefits) for all program participants who are in this ETOP program will be provided by the State of Florida.

The Business Agrees to:

- Agrees to insure that the participant hand carries their timesheet to CareerSource Escarosa or the participant/employer faxes the timesheet from the following fax number **(850) 607-8851** by 1:00 PM each Monday.
- Provide work sites designed to offer program participants with a non-paid, job-training experience commonly referred to as "Work Experience".
- Not disclose the program participant's status as a recipient of public assistance to anyone other than management.
- Make the terms and conditions of this ETOP program the same as for paid employees to the fullest extent possible.
- Provide a training outline of job skills that the participant will obtain during their ETOP program.
- Provide training to program participants to enable them to obtain the knowledge and skills essential to adequately perform the job as described in the Work or Training Outline.
- Please call the Escarosa front desk at 850-607-8800 if one or more of the following situations occur:
  - The participant failed to attend the initial interview, refused a suitable worksite training offer, or voluntarily quits.
  - The participant was not accepted for participation in the training program.
  - The Business experienced any problems with the participant, including: absenteeism, sickness, or other problems that may arise.
  - The participant secured unsubsidized employment.
  - The Business terminated the participant's training.
- Submit signature card for all supervisors authorized to sign participant timesheets.

Manner of Service Provision:

- Escarosa will approve the Work/Training Outline for each participant before training begins.
- The business will provide the necessary instructions, supervision, and equipment to train the participant.
- The business will teach the program participant the skills necessary for entry-level work in the designated job title.
- No individual may participate in the ETOP program funded by Escarosa unless Escarosa officially refers the individual to The Business in accordance with this memorandum.
- No trainee shall displace a currently employed worker.
- A participant may not spend more than 90 days at your site.

BUSINESS: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON: _____ TITLE: _____

JOB TITLE(S): _____

COMMENTS: _____

WORK SITE REPRESENTATIVE	EMPLOYMENT & TRAINING REPRESENTATIVE
Print Name: _____	Print Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

WELFARE TRANSITION AND SNAP PROGRAM
AUTHORIZED WORK SITE SIGNATURES

FOR EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM

Please List All Authorized Management and Site Supervisors below who can sign off on ETOP Timesheets.

Work Site: _____

NAME (PLEASE PRINT)	**SIGNATURE**
1.	
2.	
3.	
4.	
5.	
6.	

THANK YOU!!

WORK EXPERIENCE REFERRAL
WORK SCHEDULE

EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM
6913 N. 9th AVENUE
PENSACOLA, FL 32504

Participant Name: _____ **RFA#: _____**

Required Number of Hours per Week: _____ **Start Date: _____**

Career Advisor:_____

Worksite:_____ **Site Supervisor: _____**

EMPLOYER INSTRUCTIONS:

1. **Conduct Interview to approve or disapprove.**
2. **If approved, fill in Worksite, Site Supervisor, and work schedule below based on your business needs and the number of hours the participant needs listed above.**
3. **The start date is the latest date that the participant must start at your worksite.**
4. **Please sign and date form, and return to the participant.**
5. **If you have any questions, please call 850-607-8800.**

WORK DAY	TIME IN	LUNCH		TIME OUT	Total Hrs. Scheduled
		Out	In		
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					
				TOTAL SCHEDULED EACH WEEK	

Participant Signature: _____ **Date:** _____

Site Supervisor: _____ **Date:** _____

CA Signature: _____ **Date:** _____

Chap IV Exh "C"

Employment & Training Opportunity Program (ETOP) Requirements

Participant Name: _____

Date: _____

You have been assigned to complete **35** hours per week of activities. Participation is mandatory. Failure to complete the required number of hours per week may result in a sanction and loss of benefits.

As an ETOP participant you are expected to adhere to the ETOP requirements as outlined below:

1. Your assigned worksite supervisor will provide you with a weekly work schedule. A copy of this schedule MUST be returned to your Career Advisor (CA) no later than _____ .
2. You are expected to work as scheduled. Any change to your schedule MUST be pre-approved by the worksite supervisor and your CA.
3. All personal appointments MUST be scheduled around your assigned work schedule. No exceptions!
4. Should an emergency arise that requires you to miss your scheduled work time, you MUST call your worksite supervisor and CA prior to your scheduled shift. You must also provide documentation to your CA for all absences. Any hours missed due to absences MUST be made up the same week.
5. You are expected to obey all rules and regulations of your assigned worksite.
6. Use of any electronic personal device (cell phone, tablet, and iPod) is not authorized during work hours. These devices may only be used during scheduled or approved breaks. Talking or texting on your cell phone is not authorized during work hours.
7. If Smoking is permitted, it is only authorized during scheduled breaks and only in areas designated by the worksite.
8. You are expected to wear the appropriate work attire required by your assigned worksite. This also includes good personal hygiene and grooming practices.
9. Disruptive behavior and/or illegal activities at the worksite will result in immediate removal from the worksite and may include loss of benefits. Inappropriate language at the worksite will not be tolerated.
10. At no time are you authorized to change your assigned worksite without first getting approval from your CA.
11. I understand that any information I receive at the ETOP worksite is to be held in strict confidence. Failure to do so could result in criminal prosecution as well as loss of cash benefits.

The Employment & Training Opportunity Program requirements have been explained to me. I understand that failure to comply with the ETOP requirements could result in the loss of my cash benefits and/or food stamps.

I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITIES

Participant Signature_____ Date _____

Career Advisor _____ Date _____

CareerSource ESCAROSA

WELFARE TRANSITION AND SNAP PROGRAMS
EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM
WORK SITE TRAINING OUTLINE

1. Work Site name / address: _____

_____

2. Work Site phone #/contact name: _____
3. Work site hours _____ Work site days _____
4. Job Title: _____
5. Trainee Name: _____
6. Start Date: _____ Start Time _____
7. Position description (skills, requirements)s

_____

_____

_____

_____

8. List job duties in which training will be provided:

_____

_____

_____

_____

EXCESSIVE ABSENTEEISM WILL NOT BE TOLERATED AND COULD RESULT IN A SANCTION.

Participants must make up all missed hours even if good cause is given
All hours must be made up the following week

9. Hours per week: _____
10. Scheduled time: _____
11. Length of training: _____

_____
Participant's Signature

_____ _____
Authorized Work site Representative **ETOP** Representative/Counselor

WELFARE TRANSITION AND SNAP PROGRAMS
WORK SITE JOB SKILLS TRAINING (JST) OUTLINE

1. Work Site Name/ Address: _____

_____

2. Work Site Phone#/Contact Name _____
3. Work Site Hours _____ Work Site Days _____
4. Job Title: _____
5. Trainee Name: _____
6. Start Date: _____ Start Time _____
7. JST Hours Per Week: _____
8. Length of Training: _____

JST Training Activities:

Employer's Policies and Procedures
Using online resources, work on improving typing speed and accuracy
Work on improving proficiency in Microsoft Office Suite using www.gcflearnfree.com

_____
Participant's Signature

_____ _____
Authorized Work Site Representative ETOP Representative

As the authorized work site representative, I understand that only ETOP and/or Internship hours are covered by Workers Compensation Insurance provided by the State of Florida. Any incident that occurs during JST hours would be covered solely by the participant's Medicaid Insurance.

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6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

Participant Name:
RFA#:
DATE:

1. I, _____, understand that I am being assigned at _____, to complete my required work activity hours as listed on my Individual Responsibility Plan (IRP). I have been advised that this employer is / is not required by the State of Florida to conduct a Level II background check on all employees and volunteers prior to starting work. I am aware that a Level II background check will include both juvenile and adult records. I have voluntarily discussed any and all background issues with my Career Advisor. I understand that if I fail to disclose any background issues that are discovered as a result of the Level II background check, I will be required to reimburse CareerSource Escarosa for the cost of the Level II background check by forfeiting my transportation services for 2-5 weeks. The cost of Level II background checks range from $35.45 to $110.00.

2. I further understand that if I am offered and accept employment and the employer requires that I have specific items prior to the start of employment, and I fail to show up or quit I will be sanctioned for missed activity hours resulting in a loss of benefits. I also understand that I will be required to reimburse CareerSource Escarosa for the cost of the specific items by forfeiting my transportation services upon re-entry into the Welfare Transition Program until full reimbursement for the items is made.

Participant Signature: _____ Date: _____

WT Staff Signature:_____ Date: _____

Chap IV Exh "G"

CareerSource ESCAROSA

EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM

CLIENT EMERGENCY CONTACT INFORMATION

Client Name: _____

Age: _____

Address: _____

_____

Participant Emergency Contact Name (Please Print): _____

Relationship to Client: _____

Participant Emergency Contact Number: _____

If a client is currently assigned to your worksite and gets injured, please call the below listed Career Advisor:

_____

WT/SNAP Career Advisor: _____

WT/SNAP Career Advisor Number: _____

WT/SNAP Weekly Activities Time Sheet

Name: _____ Last 4 SSN#: _____ Career Advisor: _____

Week Of: _____ Employment YES or NO: _____ Hourly Wage:_____

I understand that CareerSource Escarosa is intended to educate and assist individuals in the attainment of employment. Submitting this form to the WT/SNAP program office is an affirmation that the following activities have been completed. I must continue with these activities each weekday until I am directed not to do so by my Career Advisor. I must follow through on job leads and work with CareerSource Escarosa staff to improve my opportunities of finding a job. This timesheet must be submitted to CareerSource Escarosa by 1:00pm each Monday.

Fax: Pensacola (850) 607-8851 – Milton (850) 983-5330 – Century (850) 366-4015

Date	Type of Activity or Name of Class	Time In:	Time Out:	Time In:	Time Out:	Total Hrs: (completed by WT/SNAP Staff Only)	Supervisor or Instructor Signature:

(For WT/SNAP Use Only)

For Official Use Only:	JPR Week Being Verified:		Hours Credited:		Career Advisor Signature:	

Participant Signature: _____ Date: _____

WT/SNAP External Job Search Log

Name: _____ Last 4 SSN#: _____ Career Advisor: _____

Submitting this form to the WT/SNAP program office is an affirmation that an active job search to the following employers has been completed. You will receive 1 hour of job search credit for each completely filled out contact.

PLEASE PRINT in BLUE OR BLACK INK **This Job Search will be randomly verified and must be completed with a pen.**

Date of Job Search:____/____/____			
	Business Name	**Street Address or Website**	**Position**
1			
2			
3			
4			
5			
6			
7			

(For WT/SNAP Use Only)

For Official Use Only:	JPR Week Being Verified:		Hours Credited:		Career Advisor Signature:	

Participant Signature: _____ Date of Submission: _____

CareerSource Escarosa

EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM

EMPLOYEE EVALUATION

Employee Name: _____ Date:

Employee Site: _____ Evaluation Period: ☐ 30 Day ☐ 60Day

Supervisor Name: _____ OR ☐ 90 Day

	PERFORMANCE FACTORS	RATING				
		1=Poor	2= Fair	3=Satisfactory	4=Good	5=Excellent
1.	***Job Performance***: Demonstrates the basic knowledge and experience necessary to produce the results required by the job.	☐	☐	☐	☐	☐
Comments:						
2.	***Personal Grooming***: Practices good personal hygiene skills; dresses in appropriate attire for work setting; overall, general appearance is appropriate for job site.	☐	☐	☐	☐	☐
Comments:						
3.	***Attendance/Punctuality***: Prompt, reports to work on time. Leaves at scheduled time.	☐	☐	☐	☐	☐
Comments:						
4.	***Attitude***: Takes a positive and helpful approach toward the public and other employees. Responsive to the needs of others. Has positive work attitude.	☐	☐	☐	☐	☐
Comments:						
5.	***Team Player***: Cooperates with others to accomplish goal (s); interacts well with co-workers and supervisor.	☐	☐	☐	☐	☐
Comments:						
	TOTAL SCORE					

6. If you had an opening would you hire this individual? ☐ **YES** ☐ **NO**

Comments:

7. Would you provide this individual with a short written reference to take with them for future job interviews? ☐ **YES** ☐ **NO**

Comments:

Scorers Signature **Date**

PLEASE FAX THIS FORM TO: **FAX #: 850.607.8851**

Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CHAPTER V

WT/SNAP
Career Advisor Services and Responsibilities

V. WELFARE TRANSITION (WT)/SUPPLEMENTAL NUTRITION ASSISTANCE (SNAP) PROGRAMS CAREER ADVISOR SERVICES AND RESPONSIBILITIES

A Centralized Career Management System (CCMS) will be located full-time within the CareerSource Escarosa Centers in Pensacola and Milton, and part-time in Century. These CareerSource Centers will be the main point of contact for residents within those vicinities.

Welfare Transition and SNAP Career Management includes linking participants with appropriate activities based upon assessment of the participant's skills and abilities if possible. It also includes tracking participant performance on an ongoing and consistent basis in the state One-Stop Service Tracking (OSST) system.

Together, the Career Advisor (CA) and the participant will complete the Individual Responsibility Plan (IRP) located in OSST (or a paper copy if OSST is not available) that includes the participant's short-term and long-term career goals and provides the steps that the participant must achieve to become self-sufficient. The CA and the participant will work together to make progressive steps to self-sufficiency. Cases will be managed in the county in which the participant resides, unless otherwise approved by the WT/SNAP Programs Manager.

A. Career Advisor (CA) Responsibilities

The CA is responsible for all facets of case management on all participants assigned to them. This includes but is not limited to: completing verbal and written assessments, assigning activities, tracking and monitoring progress, sanctions and data entry into OSST. WT/SNAP requires that the CA have contact with all mandatory participants as needed or at least every 90 days as long as the IRP is current, and the participant has completed their assigned hours as required. This may be accomplished via in person, phone, or virtual appointments; via walk-ins (if available); or in some instances via email.

The CA is also responsible for all documentation entered into each participant's case file, issuing pre-penalties and sanctions and issuing support services to aid in removing participant barriers that hinder economic self-sufficiency.

1. **Appointments**

   The WT/SNAP Career Advisors have the responsibility of making contact with the participant on a consistent basis. Every participant that becomes mandatory will be issued an appointment with their career advisor utilizing the Referral Form (Exhibit "A"). The career advisor will conduct an initial career advisor appointment within 30 days of the client becoming mandatory and complete a desktop orientation.

   a. Initial Career Advisor Appointment

   During this appointment, the CA will review all assessments and the Opportunities and Obligations (Exhibit "B") to complete the desk orientation and accomplish the following with the participant:

   - Restate the Goals and requirements of the WT or SNAP Program
   - Complete the Oral Assessment
   - Discuss items on all Assessments
   - Review Previous Case History
   - Create IRP in OSST or in paper format
   - Develop Objectives or Steps to Self-Sufficiency
   - Develop Plan to Overcome Barriers
   - Provide Support Services as needed and based on budget
   - Assigns Activities
   - Advise Participant of Obligations, Penalties and Sanctions
   - Record Contact via Case Note in the OSST system

- Refer to other Workforce Professional's or agencies as needed

2. <u>Individual Responsibility Plan (IRP)/Objectives or Steps to Self-Sufficiency</u>

A WT/SNAP Individual Responsibility Plan (IRP) will be required for all participants referred to WT or SNAP and must be initiated and completed within 30 days of his/her case becoming mandatory. Each client submits vital information for the IRP in OSST by going to OSST Client and completing their WR Orientation assessments. The CA will complete the IRP during a CA appointment with the client utilizing all assessments and creating Objectives or Steps to Self Sufficiency. The IRP will also be updated as follows:

- As needed, but at a minimum of every 90 day
- When there is a change in assigned activities
- When a participant moves from medical status (ARP) to mandatory work-ready status and/or from mandatory to medical.
- When a goal has been achieved or changed
- If there is a change in barriers
- If there is a change in life circumstances
- If there is a change of Career Advisor

The CA will also review the participant's short-term and long-term career goals. If the participant does not have any clearly defined goals, the CA conducts oral interviews and assessments to begin the process of goal setting. All goals must be reviewed at each CA appointment.

The IRP specifies the activities, services, and goals agreed upon by both the CA and the participant. This plan must contain the progressive steps that the participant must take to complete their objectives and become economically self-sufficient.

At a minimum, the IRP along with the assessments will include, but is not limited to:

a. Needs and Barriers
b. Support Services
c. Referred Services
d. Employment and/or Career Goals
e. Short-Term Goals
f. Assigned Activities including number of required hours
g. Expected Completion Dates and/or deadlines
h. Criminal History
i. Education and/or training history
j. Skills Data
k. Employment History
l. Hours of participation
m. Objectives or Steps to Self-Sufficiency

After the participant has completed the CA interview, both the CA and the participant will sign and date the IRP. The participant's needs and barriers will be recorded on the Plan Development or Assessment page in the OSST system.

A client who has any limitations which restrict them from completing any or all assigned activity hours will be referred to their Physician with a Medical Verification form AWI-WTP 2288 (Exhibit "C") for completion. This form must be signed by a licensed Physician (ME or DO/OS) or an Advanced Clinical Nurse (ACN) and will be utilized by the Career Advisor (CA) to complete

an Alternative Responsibility Plan (ARP) in OSST. **For all SNAP participants, this form will be sent immediately to DCF via the chain of custody for possible exemption or exception to the SNAP program.** The CA will adhere to the attending Physician's recommendations when completing the ARP. If for any reason the attending Physician will not complete form 2288, a letter or any documentation signed by the attending Physician or ACN will be used, provided it includes the following information:

a. Must specify the nature of the disability

b. The duration

c. The number of hours per week the client may participate (if any)

d. Limitations (if any)

e. The course of treatment (if any)

All participants assigned to a medical deferral will be seen once a month. The CA will update the ARP every month during the regularly scheduled CA appointment. While the client is under a medical deferral, no support service will be authorized. If the medical verification form is marked permanent, the client will be counseled regarding the submission of an SSI/SSDI application. The medical verification form AWI-WTP 2288 will be updated every 3 months. Every medically deferred client must follow the treatment plan established by their attending physician. The client must submit a treatment plan from their physician and follow that plan turning in proof of scheduled appointments, treatment, counseling and/or therapy to their CA. If the client desires to return to normal activities prior to the end of their medical deferral, they must have their attending Physician complete a voluntary participation form (Exhibit "D") or obtain a letter from their attending Physician prior to returning to normal activities.

3. **<u>Assigning Job Search and Job Readiness / Validation of Hours</u>**

During the initial CA appointment, the CA, in accordance with State and Federal guidelines, will assign participants to work activities with the following guidelines.

a. Participant cannot be assigned to more than four (4) consecutive weeks of job search and no more than 120 hours for a single parent with a child under six or 180 hours for all other participants during any 12-month period**. <u>For all SNAP participants, the CA will assign 39 hours per month or less of job search and/or job search training. The rest of the 80 required hours per month for SNAP will be completed by assigning an additional qualifying component.</u>**

b. If the State of Florida is declared a "Needy State", then CareerSource Escarosa will follow state guidelines.

The procedure for validating all Job Search and Job Readiness hours is done by electronic staff signatures for supervised activities at the Center in the electronic timesheet program or the WT/SNAP weekly activity timesheet. Validation of external job search activities is done through clients turning in proof of business visits or by contacting 10% of the participant's external job search contacts by the WT/SNAP staff.

4. **<u>Assigning Employment Training Opportunity and Placement (ETOP) and Internships (Work Experience) / Validation of Hours</u>**

a. Employment Training Opportunity and Placement (ETOP)

During the initial CA appointment, the CA, in accordance with State and Federal guidelines, will assign participants to work activities.

The CA will assign a participant to ETOP based upon the calculation established by the state of Florida which maximizes the number of required hours. The required WT hours are calculated by taking the total of TANF and Food Stamp benefits divided by the Florida minimum wage or national minimum wage, whichever is greater. The total equals the monthly required hours. Weekly hours are calculated by the monthly total being divided among the weeks in each month (TANF + FS = $$ / Minimum Wage = number hours per month divided by 4.33 = Number of hours per week). WT's requirement is twenty-two (22) hours MINIMUM per week of core activity participation unless the calculation falls below 22 (example 19.16). In this example, as long as the participant completes their assigned 19.16 hours a week, they will automatically get deemed up to 87 hours, which is the State minimum for a core activity. If a client's calculation comes out to more than 22 hours, their hours may be reduced to the 22 minimum to allow additional hours for school or training.

For SNAP, the required hours are calculated by taking the household's food assistance allotment divided by the higher of the federal or state minimum wage. The result is further divided by the number of individuals in the food assistance group.

In either case the client's actual hours completed MUST NOT exceed the MAX Worksite Hours for the Month. Missed hours may be made up but NO client will be assigned or allowed to complete more than 40 hours of an assigned ETOP or work experience assignment in a week.

To assign ETOP, the CA will provide a ETOP Work Experience Referral (Exhibit "E") along with a list of approved worksites to the participant. The participate will then call and / or visit the approved worksites for an interview with the site supervisor for

work assignment. Once a site is secured, the site supervisor will complete the work schedule on the work referral then sign and return the form to CareerSource via the participant. The CA will provide the client with a copy of the work referral and place a copy in their case file.

Once the client starts their ETOP at their assigned site, the CA will monitor each client's performance to ensure they conduct themselves in a professional manner while performing quality work expected of a paid employee.

The procedure for validating ETOP hours at all locations is done by the client or worksite supervisor logging into the electronic timesheet program and recording the hours. For worksites that do not participate in the electronic timesheet program, submit a WT/SNAP Weekly Activity Time Sheet (Exhibit "F") signed by the participant and the worksite supervisor. The CA will enter the JPR hours in the OSST system and retain the record in the case file. A strike through on the timesheet may be completed and initialed by the CA ONLY.

Note: For a WT participant, deeming is automatically giving a participant 87 CORE hours if they have completed all assigned activity CORE hours based on the calculation without using excused time. This is completed by DCF.

b. Work Experience

The assignment of and validation of hours for Work Experience is completed exactly the same as assigning a participant to ETOP. All calculations and rules for the hours are also the same. Work experience must include:

- Job title

- Clear Job description
- Connection between the site and participant's goals
- Performance Benchmarks
    - What will they achieve
    - What skills they will gain
    - Employer expectations
- Goals
- Time Limits
- Outcomes

5. <u>Assigning Vocational Education / Validation of Hours</u>

a. All SNAP clients who are enrolled in school at least half time can meet an exemption with DCF. The CA must obtain a copy of the class schedule and/or school enrollment and submit to DCF via the chain of custody. The CA will continue to record hours as listed below until the client's case is closed as exempt.

b. WT criteria for vocational training are as follows:

i. Vocational Education is a primary program activity and may not exceed a total of 12 months in a lifetime. The CA will counsel the applicant on all requirements, responsibilities, and limitations of the WT VOCED Program.

ii. During the CA appointment, the CA shall ensure that the applicant has the following documents:

- Completed School Enrollment Verification Form (Exhibit "G")
- Copy of Class Schedule
- Copy of Course Syllabus (for each course enrolled)

- School Representative Signature and Study Hour Form (Exhibit "H")
- Understanding of Vocational Education and Training Policy Statement (Exhibit "I")
- WT/SNAP Weekly Activity Timesheet

At the start of each semester, a new class schedule, course syllabus for each class and a School Representative Signature and Study Hour form must be submitted.

c. SNAP Vocational Training – Provides an opportunity for ABAWD's to participate in specific training to gain knowledge, skills and competencies required for particular occupations or trades. This activity may be combined with job search or job search training or other qualifying components to achieve the required 80 hours per month.

ABAWD's assigned to this activity may be allowed one hour of study time for each hour of class time completed, if verification is provided of the actual time spent in the classroom.

SNAP E&T funds may be used (if funding permits) if federal funds are not used or the ABAWD cannot obtain federal assistance such as Pell Grant or the ABAWD was not eligible for the funds.

d. Validation of Hours:

i. The Procedure for validating Vocational Education hours is done by the submission of the WT/SNAP Weekly Activity Timesheet signed by a school official and the participant.

ii. In accordance with the work verification plan, the CA will enter hours for time the participant has actually attended class, according to guidelines established by the school he/she is attending. In addition to actual classroom hours, countable hours may include, supervised time spent in curriculum, required labs and clinical settings, supervised study halls (all verified by a school official signature) as well as up to one hour of unsupervised homework time for each hour of class time. Total homework time counted for participation cannot exceed the hours required or advised by the educational program instructor. The CA will update the OSST system and retain the record in the case file. WT/SNAP will not accept any hours for educational purposes from any institution not recognized by the state of Florida.

e. Applying For Tuition Assistance

Payment for Tuition and books will be obtained through the participants PELL grants and/or financial aid. All WT/SNAP Clients may be referred to the WIOA Program.

6. Assigning Employment (Subsidized/Unsubsidized) or On-the-Job Training - Validation of Hours

The CA will work with the other services of CareerSource Escarosa, Employ Florida system and other online employment advertisements and cold calls in addition to the ETOP and Work Experience employers to assist participants with employment opportunities.

After a participant obtains Employment, WT/SNAP requires that one of the following documents be submitted for verification purposes: (The CA will not record the Employment information into the OSST system until this documentation is secured).

a. DCF Employment Verification Form
b. ELC Employment Verification Form
c. HUD Employment Verification Form
d. TALX Employment Information
e. The Work Number Information
f. Any Recognized Employment Database
g. Pay Stubs
h. Company employment letters on letterhead with start date, rate of pay, hours per week, pay cycle, contact name and number.
i. As a last option, oral contact with the CA may be used, but must include the following: (All information must be placed in the OSST system case notes and a copy retained in the participant's case file.)
- Date of call
- Name of person and title CA talked to
- Phone number of Employer
- Name of Employer
- Address of Employer
- Hourly Rate
- Employment Start Date
- Payment Schedule

The procedure for validating Employment hours is done by the submission of WT/SNAP Weekly Activity Time Sheets until the first pay stub is received. After the participant begins receiving pay stubs, they should be submitted according to the pay cycle previously stated on the Employment Verification Form. If a participant is being paid by check, a copy of the check and the Weekly Activity Time Sheet will be submitted to validate hours. Hours will be projected in accordance with State guidelines. The CA will update the OSST system and retain copies of the form and/or paystubs or check in the case file.

7. <u>Assigning Job Skills Training (JST) - Validation of Hours</u>

Job Skills Training is a WT activity comprised of education or training to obtain skills required by an employer so the participant can obtain employment, adapt to the changing demands of the workplace and advance in their chosen occupation. This may also include customized training for an employer or general training that prepares an individual for employment with an employer. It must be explicitly focused on skills needed for a job or combined in a training program.

During a CA appointment, the CA in accordance with State and local policy will assign participants to work activities. The CA may assign the participant JST in conjunction with their CORE activity to meet required activity hours for each week. To be assigned to this activity, the participant must meet the following requirements:

a. Have a High School Diploma or GED

b. Have a Clearly Defined Employment Goal (Supported by the Occupation and Information Network (ONET) or the Employ Florida Marketplace (EFM) system)

There a several ways JST may be accomplished. A participant may be assigned (but is not limited to) the following:

- Self- Paced Computer Tutorials
- Welfare Transition Program Work Site Job Skills Training (JST) Outline (Exhibit " J")
- General Training for Employment
- Other Post-Secondary Education (not meeting WT VOCED Policy)

The procedure for validating Job Skills Training Directly Related to Employment hours is done by the electronic timesheet program or staff signatures on a weekly activities' timesheet for

supervised activities at the center, worksite or an approved institution.

8. <u>Education Directly Related to Employment (EDRE) - Validation of Hours</u>

Education Directly Related to Employment (EDRE) is a WT activity limited to participants who do not have a high school diploma or GED. Education directly related to a specific occupation, job or job offer may include adult basic education, language instruction, or education leading to a GED when required by an employer. On a case-by-case basis, CA's may enroll individuals with high school credentials if the following are true:

- The high school credentials are from another country
- Assessments indicate that the individual cannot function at high school levels according to United States standards

The CA may support the participant's activities with an educational activity such as EDRE who have a clearly defined employment goal supported by ONET or EFM.

During a CA appointment, the CA will assess the participant by reviewing all assessments and completing an IRP on the participant. If the participant wishes to obtain a High School Diploma or GED, this educational activity may be assigned. After the participant has been accepted and enrolled into the educational program, the following forms must be submitted:

- WT School Verification Form
- Copy of Class Schedule
- Instructor Signature Form

After the above forms have been submitted and reviewed by the CA, the participant will be assigned to EDRE. If the participant is a

single parent (PA), ETOP or Work Experience will be his/her primary activity. The hours of Core Activities will not be reduced lower than the **MINIMUM** requirements to accommodate for this education activity.

This is a Core Activity for Teen Parents.

The procedure for validating Education Directly Related to Employment hours is done by staff signatures for supervised activities at the Center or an approved institution.

9. <u>Satisfactory Attendance at a Secondary School</u>

This is a WT activity that requires regular attendance at a secondary school or in a course of study leading to a certificate of general equivalence is limited to participants without a high school diploma or GED. Participants assigned this activity must attend classes regularly. CA's may also enroll participants with high school credentials in this activity, if the following are true:

- The high school credentials are from another country
- Assessments indicate that the individual cannot function at high school levels according to United States standards

This activity may also include other literacy education if required to secure a high school diploma or a GED and may include adult basic education directly related to obtaining high school diploma or GED. The CA may assign the participant to this activity if the participant is a single parent (PA). ETOP or Work Experience will be his/her primary Core activity. The hours of Core Activities will not be reduced lower than the **MINIMUM** requirements to accommodate for this education activity.

During a CA appointment, the CA will assess the participant by reviewing the Initial Assessment, TABE and completing an IRP on

the participant. If the participant wishes to obtain a GED or High School Diploma, this educational activity may be assigned. After the participant has been accepted and enrolled in the education program the following forms must be submitted:

- WT School Verification Form
- Copy of Class Schedule
- Instructor Signature Form

This is a Core Activity for Teen Parents.

The procedure for validating Satisfactory Attendance in a GED program is done by staff signatures for supervised activities at the Center or an approved institution.

10. Job Search Training

This is a SNAP activity that provides training activities to assist in the development of essential employment skills for the ABAWD to secure and retain employment. Job search training activities may be conducted directly in the Career Center or through community partners. Job search training may include, but not limited to, workshops that address life skills, time management, soft skills, interpersonal skills, decision making, job seeking skills, job retention skills, appropriate dress for the workplace and career planning. Like job search, job search training hours are limited to 39 or less hours per month and may be combined with other allowable activities to achieve 80 hours per month.

11. Basic Education

This is a SNAP activity. Allowable education activities may include, but are not limited to,

- Adult basic education

- Remedial education
- High school completion or GED
- Post-secondary education
- English for speakers of other languages (ESOL)

ABAWD's assigned to this activity may be allowed one hour of study time for each hour of class time completed, if verification is provided of the actual time spent in the classroom.
SNAP E&T funds may be used (if funding permits) if federal funds are not used or the ABAWD cannot obtain federal assistance such as Pell Grant or the ABAWD was not eligible for the funds.

12. <u>Referral to Vocational Rehabilitation or Other Mental Health Counseling</u>

The CA may refer a Participant for a specialized assessment to determine more in-depth career abilities, interests, mental health issues, substance abuse concerns, and/or special physical limitations.

This may be in conjunction with a work activity, unless a doctor's evaluation precludes work activity, in which case the participant may be required to begin treatment in lieu of their work activity. The CA will utilize Division of Vocational Rehabilitation Referral/Application (Exhibit "K") to schedule an intake interview.

An appropriate referral may include, but is not limited to, the following criteria:

a. A participant has low TABE scores (less than 5.0) and/or a known learning disability and also meets criteria "**a**" listed above.

b. A participant scores 12 or higher on the Learning Needs Screening Tool assessment and has a referral from the Disability Navigator.

c. A participant has physical and/or mental problems that do not prevent them from working but do require work limitations.

When a participant is evaluated at Voc-Rehab, the results will be forwarded to his/her CA for review. The participant may then either be placed in a regular or structured work setting with certain guidelines or limitations as per the recommendation.

A Client who is under treatment for Substance Abuse or Mental Health or who is referred to a Substance Abuse or Mental Health (SAMH) Professional shall utilize the Substance Abuse and Mental Health (SAMH) Treatment Verification (Exhibit "L") to be completed by the SAMH Professional and returned to the Career Advisor for inclusion into the client's case file. For all SNAP clients, the CA will inform the client to contact DCF for a possible exemption or exception while also trying to get the form should DCF require proof. If the client is in an outpatient treatment program, he/she will be given up to 5 hours of participation each week. If a client is in an inpatient treatment program, they may complete all required hours through that program. All counseling hours must be documented utilizing the Weekly Counseling Session and Attendance sheet (Exhibit "M"). The CA is responsible for completing an Alternative Responsibility Plan (ARP) in OSST for this assignment.

13. Referrals to Community Organizations

During all CA appointments, the CA may recognize additional barriers that hinder employment. The CA may refer Participants to community agencies to determine more in-depth career abilities, interests, mental health issues, substance abuse concerns, special physical limitations and/or support services needed such as rent utility bill assistance, clothing etc.

If new barriers are disclosed to the CA, the CA can submit new referrals at any time that it is deemed appropriate.

This may be in conjunction with a work activity, unless a doctor's evaluation precludes work activities, in which case the participant may be required to begin treatment in lieu of their work activity.

14. Entering Information into the One-Stop Service Tracking (OSST) System

Each CA is responsible for maintaining all case information in the OSST system and its accuracy. This includes but is not limited to:

a. Oral Contacts with Participants
b. CA Appointments
c. Case Notes
d. Activities
e. Services
f. Deferrals
g. Walk-in's
h. Contact information
i. Employment
j. School
k. Needs and Barriers
l. Client being difficult, aggressive or violent
m. Any other pertinent case information

15. Validation of Hours, Entering Job Participation Rates (JPRs) and Authorization of Transportation Assistance

Each week, participant timesheets or paystubs (when received) must be submitted to WT/SNAP with documented weekly activity hours the participant has completed for that week or pay period. Hours are then entered in to OSST and tracked for the month. Timesheets and paystubs will be annotated on them by the CA for the correct number of hours completed for each JPR week and signed by the CA. If a WT participant completes all assigned activity hours and

make their participation rate for the month, they are added to the authorized transportation list by their CA. If a SNAP client completes all their required hours for the month and submits either a gas receipts, a bus pass or self-attestation form, a FSR will be entered into OSST for the amount up to 25.00 for reimbursement.

When timesheets are submitted, participants are required to submit documented "good cause" for missing any hours. Good cause is for penalty actions only and does not count for hours towards transportation. Clients will only receive transportation assistance for completing all required hours.

ANY DISCREPANCY ON A JPR THAT REQUIRES A CORRECTION WILL BE COMPLETED BY THE CA ONLY AND INITIALED NEXT TO EACH CORRECTION.

16. Good Cause Procedures

a. WT Participant

If a participant misses an assigned or scheduled activity, WT requires him/her to provide a documented "good cause" reason as to why he/she did not attend their activity.

For the first act of non-compliance, participants are required to submit "good cause" documentation and/or comply, as well as contact their CA within ten (10) calendar days of the actual failure date. If a participant fails for a second or more acts of non-compliance within a thirty (30) day period, the participant must submit "good cause" documentation within three (3) business days of his/her failure.

"Good Cause" reasons are listed below:

1. Domestic Violence: When a participant provides documentation indicating that compliance would

present a danger due to domestic violence or if, during counseling, the participant expresses a fear of danger due to domestic violence.

2. Good cause may also be given if the participant suffers mental and/or physical impairments related to past occurrences of domestic violence. In all domestic violence situations, an alternative responsibility plan must be completed (Refer to "Domestic Violence," Chapter VI).

3. Medical Incapacity: When a participant provides written documentation from a medical doctor that states the date(s) of his/her incapacity.

4. If the date of the failed activity is within the period noted in the document, then good cause may be given.

5. Outpatient Mental Health or Substance Abuse Treatment: When a participant provides proof that he/she attended treatment during the time of the assignment.

6. The mental health or substance abuse professional must be recognized in the community and must provide verification of the participant's attendance and participation in the program.

7. Natural Disasters: When the state declares a "State of Emergency" for the area due to a hurricane, tornado, flooding, or other natural disaster.

8. Employment: When the participant provides proof that states that he/she was unable to attend the assigned activity because of work requirements.

b. SNAP Participant

For SNAP, once DCF receives the sanction alert, they will mail a Good Cause Notice letter to the client notifying them they have a 10-business day conciliation period to provide good cause to DCF for their reason of non-compliance. If good cause is not reported then DCF generates a Notice of Adverse Action (NOAA) and mails to the client for them to comply with the local workforce board along with the penalties that will be imposed on their case.

17. Sanction Penalty and Compliance Process

During the initial CA appointment, the CA assigns a participant to work activities. The CA restates the opportunities and obligations of the participant, as well as the penalties if the participant fails to complete required work activities.

The IRP in OSST (or a paper IRP) is created along with the objectives or Steps to Self-Sufficiency developed to ensure that the participant is well aware of their obligations as required by the WT or SNAP program. If the participant fails to complete the required work activities, a pre-penalty for WT or sanction for SNAP is requested on the case as instructed in State policy.

a. WT

If the participant attempts to submit a "good cause" reason after a sanction has been imposed, the CA must take the following steps:

i. Good cause documentation must be submitted to account for the non-compliance dates.

ii. If good cause is authorized, support services are issued and ELC must be notified that childcare is continuing.

When the participant has served his/her penalty period for a level 1 sanction and requests to have their sanction lifted, the following steps must occur:

- If the client has been out of the program less than 30 days from the DCF imposed date, the participant must complete a "Steps to Compliance" (Exhibit "N")

- After completion of all steps, the sanction is then lifted with compliance in OSST and a note placed in FLA.

If a participant has received a level 2 or 3 sanction or they have been out of the WT program for 30 days or more, they must:

i. Serve out the entire penalty and reapply for TANF.

ii. Complete a Steps to Compliance packet. WT staff will enter a 487 code in OSST under skills development to allow the client access to OSST Client. Staff must also make the client an Open Applicant in OSST for access to OSST Client.

iii. Complete the State WT online WR Orientation

iv. A steps to compliance package will be verified as complete when their work registration is completed and the 494 code in OSST closed as completed. This will automatically close code 487.

b. SNAP

Good cause determinations remain the responsibility of the Department of Children and Families. However, the new process includes additional functionality in the One Stop Service Tracking (OSST) system to facilitate good cause consideration. The enhanced functionality works as follows:

1. Once a participant fails to comply, a sanction will be requested (automatic or manual) in OSST. Prior to the sanction being imposed, the good cause process will occur, and the sanction request will show up as a SNAP E&T Conciliation in OSST.
2. An interface from OSST to FLORIDA will notify DCF of the failure to comply.
3. DCF will generate a good cause notice to send to the participant. The participant will also be able to report good cause by submitting a change request through their MyACCESS account.
4. The participant has ten days to report/respond to the good cause notice.
5. If the participant reports to the career center to comply before the good cause consideration period runs out, the case manager must end the conciliation/sanction request with “complied.” In addition, if the noncompliance was requested by mistake, the case manager must end the conciliation/sanction request with “entered in error.”
6. If good cause is granted, DCF will enter the good cause information into FLORIDA, which in turn will interface to OSST.
7. OSST will automatically end the sanction request with an outcome of “good cause.”
8. The case manager should notify the participant of the outcome and instruct them to continue engagement in the assigned activities for the month.

9. If good cause is not granted, DCF will inform the participant of the denial and issue a Notice of Adverse Action (NOAA).
10. If OSST does not receive a response from the FLORIDA system or the good cause request is denied within ten days, OSST will automatically request a sanction (no staff intervention required).
11. The NOAA will inform the participant of the exact noncompliance, instruct them to report to the career center for assistance, and list the date the sanction will go into effect.
12. The participant will have up until the effective date of the sanction to comply.
13. If the participant does not comply before the effective date of the sanction, he or she must serve the full penalty period associated with the sanction level.
14. After serving the full penalty period, the case manager must give the participant a compliance activity.
15. After the compliance activity is completed, the case manager must submit a sanction lift request in OSST.
16. OSST will automatically interface the sanction lift request to the FLORIDA system for DCF to end the sanction.
17. The participant must reapply for benefits with DCF.

Once the participant reapplies for benefits with DCF, DCF will refer the participant to CareerSource to get their Sanction lifted. The participant must complete a "Steps to Compliance" (Exhibit "N") before the sanction will be lifted.

18. Exit Procedures

The WT/SNAP Career Advisor has specific exit procedures for working with case closures. Case closures occur when DCF changes the status on the IQAA and/or AGPI screen. This sends an

electronic alert from the FLA down system to the CA that the participant is no longer mandatory or required to continue with work activities for various reasons, including:

a. Employment: After DCF changes the IQAA & AGPI status, the CA will receive an electronic alert advising of the change. The CA will verify the case closure date and code as determined by DCF. At the beginning of the month in which the client does not receive cash, the CA will change the status on the case from mandatory to transitional or in a SNAP case close it.

b. Sanction: After DCF changes the IQAA & AGPI status, the CA will receive an electronic alert advising of the change. The CA will close the case after the effective date of the sanction and place a case note in the OSST system.

c. Transfers and Exemptions: After DCF changes the AICI and county code, the CA will receive an electronic alert advising of the change. The CA will close the case immediately and place a case note in the OSST system. The CA will then transfer the case to the appropriate Region/County/Unit listed on the alert.

d. All Other Reasons: After DCF changes the AGPI, the CA will receive an electronic alert advising of the change. The CA will review the FLORIDA system to verify the month of the case closure and the case will remain open until the end of the closure month. The participant is required to maintain all WT/SNAP activities until his/her case is closed.

If a participant requests to "opt out" of TANF, the participant is required to report his/her status change to their CA. The CA will have the Participant sign an opt out Statement (Exhibit "O") and forward that request immediately to DCF. The participant is to maintain all WT activities until DCF updates their AGPI status and his/her case is closed.

If a participant fails to complete their activities, a sanction can still be requested on his/her case. Once the case closure alert is received from DCF, the CA will close the case as per the closure alert and return the hard file to the closed file room.

19. Self-Employment

a. If a client is self- employed and desires to use their self-employment as activity hours the client must have the following documents:
    i. A Business License
    ii. A R-9 Tax Form
    iii. Expenditure reports that detail gross income minus business expenditures as sustained by copies of money orders, checks and other forms of proof of income or expenditures.

b. The CA will enter in OSST and report to DCF participation based on the number of hours that result from dividing the gross income minus business expenses (as verified by the documentation) by the minimum wage.

c. Participants who will not meet the minimum requirements of work activity hours will be assigned to another appropriate activity according to State and Federal guidelines.

20. Procedures for Issuing Support Services

The CA is the authority for approving all transportation assistance any other support services as appropriate.

A participant's eligibility will depend upon his/her completion of required hours. For WT clients, this will be authorized by the CA submitting the transportation spreadsheet electronically to the

Transportation Specialist. For all SNAP clients, documentation in the form of a gas receipt, receipt for a bus pass or a self-attestation form must be obtained. Then the CA will enter the FSR request into OSST.

All other WT support services, except for childcare assistance, must begin with the participant contacting his/her CA. Childcare assistance will be managed by ELC. The need for child-care assistance will be initiated during the work registration process and re-determined by the CA issuing a new referral. The Childcare Application and Authorization referral form (Exhibit "P") must be completed by the CA and sent to ELC. The CA MUST provide the client with the Early Learning Coalition Check List (Exhibit "Q").

The authorization time frames for childcare referrals are:

a. Mandatory Participants: Ninety (90) Day Childcare Referral, as long as the participant is eligible. If the participant is in need of more hours due to employment and/or school activities, the CA can submit a referral to the WT Manager for approval of hours exceeding fifty (60) total hours a week.

b. Transitional Participants: Childcare Referral for 2 years. If the participant's case has closed due to employment, the CA may authorize a transitional childcare referral provided that the employment is maintained at a minimum of twenty (20) hours per week.

Revisions and/or updates regarding a participant's status must be sent to ELC. Updates, including such items as participant eligibility, activities, and termination must be completed. A Notice of Change in Childcare Status (Exhibit "R") must be sent to the participant and all parties involved by the CA. ELC shall be the responsible entity for determining the required parent fees and for all childcare amounts to be paid.

B. WT Two-Parent Program

Two-parent Families or Unemployed Parents (UP) are defined as two parents who reside in the same household and have at least one mutual child. The procedures for two-parent families are:

1. Assigning Work Activities

Before assigning a participant to an activity, the CA will review all assessments and goals in an effort to assign activities in relation to skills, work history and employability. The CA attempts, to his or her best ability, to engage both parents and assign activities in accordance with individual needs.

a. Two-parent families who are utilizing childcare services will be assigned to an average of 50 hours a week of a core activity. At least 22 hours must be completed in a core activity for one parent and is then supplemented by core plus activities. For the monthly calculation: at least 217 hours in a core activity with 239 total hours.

b. Two-parent families who are not utilizing childcare will be assigned to an average of 30 hours of a core activity per week. This can be completed by one parent or both parents however, if one parent completes the hours, they CANNOT exceed 40 hours per week. For the monthly calculation: the family must complete at least 130 hours in a core activity with 152 total hours combined.

c. If one parent is medically deferred, unable to work, and has submitted a Medical Verification Form stating that there is a medical limitation that will last longer than 30 days, the other parent will complete an average of 30 hours of work activities per week with at least 22 hours in core activities, supplemented

by core plus activities. For the monthly calculation: the work-ready parent must complete at least 87 hours in a core activity with 130 total hours.

Childcare is authorized in this case only if the medically deferred participant can prove an inability to provide care for their child(ren) when the other parent is not present. Guidelines established by the Office of Early Learning must be followed.

If all children are school age, both parents are required to participate unless one parent is exempt or has a current medical deferral on file

2. Sanction Process

If one parent fails to complete a step on his/her Steps to Self-Sufficiency, a pre-penalty is entered into the Alternative Plan section of the OSST system for that parent only. DCF treats the case as a single unit. If there is a non-compliance of one parent, the other parent is penalized as well, even if the other parent has completed all of his/her steps. If a Sanction is imposed, it will affect both parents.

During this pre-penalty process, transportation assistance cannot be authorized to either participant until good cause or compliance is demonstrated by the parent who received the pre-penalty.

3. Case Closure

a. When a case closure alert is received for one parent, the other parent's case also closes, with an exception being when the head of household removes the other parent from the case. In this circumstance, only the parent being removed from the case will have his/her case closed.

b. When a case closes due to one parent becoming employed the employed parent only will be eligible for transitional services, with the exception of childcare. Childcare is not authorized due to the other parent being able to provide childcare.

C. WT Teen Parent Program

Participants under 20 years of age are considered Teen Parents.

The following procedure must be followed when assigning a teen parent to a work activity:

1. A teen parent who does not have a High School Diploma or GED is assigned to high school completion classes or GED classes as their core activity.

2. A teen parent who has a High School Diploma or GED will be assigned to necessary work activities.

3. Each participant is required to bring a copy of his/her current school transcripts to verify their educational status.

The initial CA appointment has the following components to be completed for a TN adult CA appointment.

a. Orientation Packet
b. Initial Assessment in OSST
c. Referral for any additional assessment (if necessary)
d. IRP
e. Childcare Referral (if needed)
f. Assignment to Work Activities as Listed Above

Teen Pregnancy Prevention Program

Despite declines in the teen birth rate over the last 20 years, teen pregnancy remains a problem. To address this problem, CareerSource Escarosa will collaborate with community organizations to implement a Pregnancy Prevention Program designed to prevent and reduce the rates of teen pregnancy throughout Escarosa. The purpose of this collaboration is to accomplish the following goals:

1. Support the TANF purpose of reducing the number of out-of-wedlock pregnancies through summer youth initiatives
2. To provide supportive services to prevent teen pregnancy.

CareerSource Escarosa relies on the theory of Positive Youth Development as a valuable tool in reducing unwanted pregnancies among the teen population. Positive Youth Development is an intentional, pro-social approach that engages youth within their communities, schools, organization, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances youth's strengths; and encouraging positive social behaviors is an integral part of every Teen Pregnancy Prevention Program funded by CareerSource Escarosa.

The prevention message may or may not be delivered implicitly; however, the focus is on encouraging planning for a future for the youth that includes cultural enrichment, experiential learning, and leadership development. CareerSource Escarosa, on a funding available basis, will solicit organizations that would like to expand their current programs by offering summer youth programs or summer camps to the community at off-the-shelf pricing to support our efforts.

These services will be provided to youth ages 13 through 19 in both Escambia and Santa Rosa Counties. The services provided, the costs for these services, and the number of youths to be served will vary based on the responses received from our partners and their availability to serve additional youth in their summer program.

CareerSource Escarosa will publish a solicitation via the local newspaper and the official website, vendors are required to complete a survey online, and once all survey results are reviewed each vendor meeting the preliminary requirements will be notified of documents needed for vendor verification. Verification will include the following:

1. Florida Division of Corporations / Sunbiz status / DUNS number / FEIN number
2. Copy of 501c (3) or Business License
3. Copy of W-9

Once the preliminary verification is complete, the Accounting Department will determine the funding eligibility for each vendor. Once a vendor is approved for funding, the following documents will be forwarded to the vendor for completion for reimbursement of summer youth program / summer camp fees:

1. Purchase Requisition
2. TANF Eligibility Form (Exhibit "S") – Registration forms may be accepted in lieu of the TANF Eligibility Form in instances where the TANF Eligibility Form was not available or returned

3. Participant Attestation Signature Sheet (Exhibit "T") – Attendance checklist may be accepted in lieu of the Signature Sheet
4. Invoice (Exhibit "U")

All Invoices must be submitted to the Accounting Department for processing by the deadline in order to receive reimbursement.

D. Fair Hearing

Local procedures for dealing with difficult situations and hearings:

1. If a participant presents a situation that cannot be resolved by front desk personnel or by a CA, the participant will be referred to the WT Manager.

2. Fair Hearing: If a participant requests a fair hearing due to an adverse action on his/her case, he/she will be referred to the local DCF staff. DCF staff will then notify the WT Manager of the Fair Hearing who will make arrangements for the CA involved to attend the fair hearing

E. Hardship Extension Procedures

A hardship extension may lengthen the time limitation of an individual's receipt of TANF. The granting of a hardship extension from time limitations does not exempt the individual from the work activity requirements.

1. DCF and/or the WT Career Advisor identifies an individual as eligible for a hardship extension if he/she is within his/her last six months of receiving TANF. DCF will fill out "Part A" of the Hardship Extension Review Form and forward it to the WT Manager who then mails an Appointment Letter (Exhibit "V") to the participant(s) for either an individual or group Hardship Extension Session.

2. The WT Manager prior to the appointment will complete a case review and consult with the participant's CA to determine for additional case information.

3. The appointment with the participant is then conducted to determine the reason(s) why an extension should or should not be granted. Hardship extensions are granted when the panel determines that an addition of time would resolve the participant's situation and enhance his/her ability to become employed.

4. The WT Manager then completes "Part B" of the Hardship Extension Form.

5. The participant fills out "Part C" of the Hardship Extension Review Form and may include an explanation as to why he/she is requesting or not requesting the extension on the back of the same form.

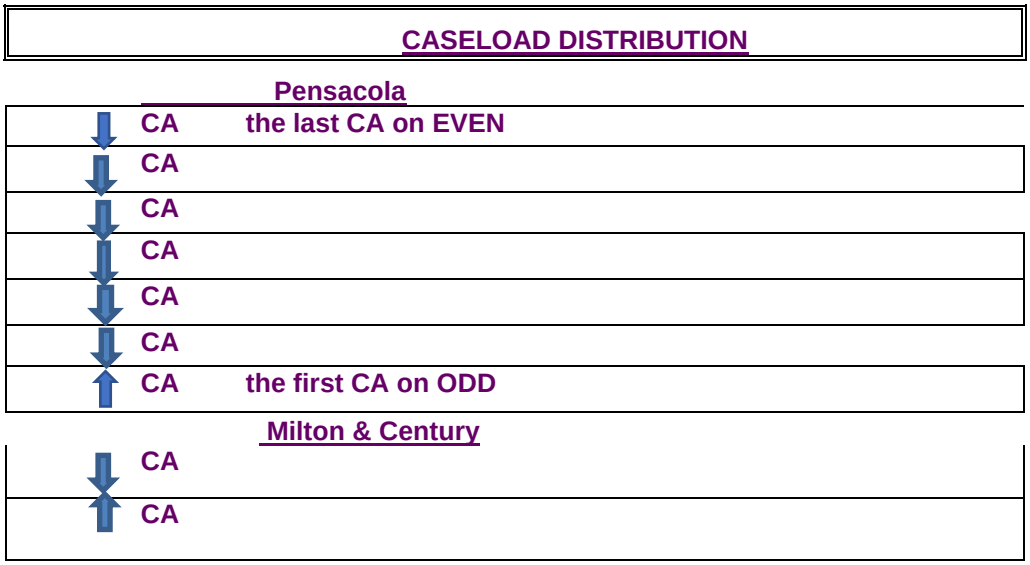
   If the participant is currently applying for SSI, all documentation must be submitted at the time of the appointment. In addition, the participant will read and sign the Hardship Extension Statement of Understanding (Exhibit "W"). For SSI/SSDI applicants only – the SSI/SSDI Time Limit Extension Review Form AWI 2289 (Exhibit "X"), must also be completed.

6. The completed Hardship Extension Review Form will then be forwarded to DCF for final approval.

F. Monitoring

CareerSource Escarosa is the Administrative/Fiscal Entity for the WT/SNAP Program and will provide monitoring and oversight for all WT/SNAP components. All participant case files both paper and

electronic shall be monitored by WT/SNAP Career Advisors. Each month, every Career Advisor shall use the Caseload Distribution to monitor another CA. During odd months, each CA will monitor the CA listed below them on the caseload distribution list with the last CA monitoring the first name on the list. Every even month each CA will monitor the name above them with the first name monitoring the last name.



Odd Months are the months of January, March, May, July, September and November.

Even Months are the months of February, April, June, August, October. (No Monitoring in December)

Every monitoring month, all Career Advisor shall use the current WT/SNAP Internal Monitoring Tool and randomly select 5 files splitting the files between the two programs. The next monitoring month 5 different files shall be randomly selected. The results shall be reported to the WT / SNAP Programs Manager each month Utilizing the WT/SNAP Internal Monitoring Tool (Exhibit "Y").

The WT/SNAP Programs Manager shall keep the results of the CA monthly internal monitoring reports and will use such reports to conduct

quarterly monitoring to include transportation, relocation, diversion services, cash severance and hardship extensions. A report shall be submitted each quarter to the Chief Executive Officer via the Chief Operations Officer. A copy of all transportation monitoring will be submitted to the Chief Financial Officer.

The WT and SNAP Programs will also be monitored by the Department of Economic Opportunity DEO or any service provider of DEO the State deems appropriate.

CHAPTER V
WT CAREER ADVISOR SERVICES AND RESPONSIBILITIES
EXHIBITS

- Exhibit “A” – Referral Form
- Exhibit “B” – Opportunities and Obligations
- Exhibit “C” - Medical Deferral Form AWI_WTP 2288(a)
- Exhibit “D” – WT Medical Voluntary Participation Form
- Exhibit “E” - ETOP Work Experience Referral
- Exhibit “F” – WT Weekly Activity Time Sheet
- Exhibit “G” –Verification of School Enrollment Form
- Exhibit “H” – School Representative Signature and Study Hour Form
- Exhibit “I” – Understanding of Vocational Education and Training Policy Statement
- Exhibit “J” – WT Worksite Training Outline (JST)
- Exhibit “K” – Florida VOC-REHAB Referral/Application
- Exhibit “L” – SAMH Treatment Verification Exhibit
- Exhibit “M” – Weekly Counseling Session Attendance
- Exhibit “N” – Steps to Compliance Packet
- Exhibit “O” – OPT OUT Statement
- Exhibit “P” – Childcare Application and Authorization and Acceptance of Childcare Assistance Forms (2 pages)
- Exhibit “Q” – Early Learning Coalition Checklist
- Exhibit “R” – Notice of Change in Childcare Status (2 pages)
- Exhibit “S” – TANF Eligibility Form
- Exhibit “T” – Participant Attestation Signature Sheet
- Exhibit “U” – Invoice
- Exhibit “V” –Assessment and Review Appointment Letter
- Exhibit “W” – Hardship Extension Statement of Understanding
- Exhibit “X” – SSI/SSDI Time Limit Extension Review Form
- Exhibit “Y” - WT/SNAP Internal Monitoring Tool

CareerSource ESCAROSA

REFERRAL FORM

NAME: _____

ADDRESS: _____ **RFA:** _____

_____ **DATE:** _____

As part of your participation in the Welfare Transition Program (WT) / Supplemental Nutrition Assistance Program (SNAP) you have been scheduled to attend the following activity or appointment shown below:

CAREER ADVISOR APPOINTMENT

DATE: _____

TIME: _____

Career Advisor: _____

PHONE: _____

at the **CareerSource Escarosa, Welfare Transition/SNAP office** located at **6913 N. 9th Ave., Pensacola, Florida 32504.**

THIS IS A REQUIRED WT/SNAP ACTIVITY. **IF YOU FAIL TO PARTICIPATE OR FAIL TO COMPLETE THIS ASSIGNED ACTIVITY YOUR CASH ASSISTANCE GRANT AND FOOD STAMPS CAN BE TERMINATED.**

If for any reason you cannot keep this appointment, you must call the telephone number listed under your assignment BEFORE **the appointment time to discuss re-scheduling.**

THIS DOCUMENTATION CONTAINS CONFIDENTIAL INFORMATION AND IS PROTECTED BY LAW. IT IS INTENDED FOR USE BY AUTHORIZED USERS ONLY AND WILL BE KEPT AS A PART OF PARTICIPANT'S RECORDS. IT IS NOT FOR PUBLIC DISSEMINATION*

CareerSource Escarosa
Welfare Transition Program

OPPORTUNITIES AND OBLIGATIONS

YOUR OBLIGATIONS

- You are required to participate in and complete all assigned program activities.
- Respond to all contacts from WT associates.
- Inform your WT Career Advisor of changes in participation, employment, family circumstances, including change of address, telephone number, child care needs, transportation problems, health problems, etc.
- Good cause reasons for failure to participate must be reported within three working days of the date of failure. Remain employed without reducing your hours or quitting unless you have good cause.
- Apply for and seek employment and accept any reasonable offer to suitable employment.

YOUR OPPORTUNITIES

- Based on your activity and the availability of funding, receive help paying for support services (transportation, child care) in order to find employment, education, or other assigned activity (ies), unless you are able to make these arrangements on your own.
- You have the opportunity to have decisions about your case reviewed by a supervisor and request a hearing if you disagree with a decision.

YOUR ACCOUNTABILITY

- I will be required to complete 35-40 hours of weekly activities
- I understand that it must be submitted on a weekly basis unless stated otherwise by a Career Advisor.

CONSEQUENCES FOR FAILURE TO PARTICIPATE

WT PENALTIES

1st Penalty: Cash assistance terminated for **entire** family for a minimum of 10 days or until compliance, whichever is longer. In addition, FOOD STAMP penalties may be imposed for one month or until compliance, whichever is longer.

2nd Penalty: Cash assistance terminated for **entire** family for one month or until compliance, whichever is longer. In addition, FOOD STAMP penalties may be imposed for 3 months or until compliance, whichever is longer.

3rd Penalty: Cash assistance terminated for **entire** family for 3 months or until compliance, whichever is longer. In addition, FOOD STAMP penalties may be imposed for 6 months or until compliance, whichever is longer.

_____
Participant Name

_____ _____
Participant Signature Date

CareerSource Escarosa
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

OPPORTUNITIES AND OBLIGATIONS

YOUR OBLIGATIONS

- You are required to participate in and complete all assigned program activities.
- Respond to all contacts from SNAP associates.
- Inform your SNAP Career Advisor of changes in participation, employment, family circumstances, including change of address, telephone number, children, transportation problems, health problems, etc.
- Good cause reasons for failure to participate must be reported within three working days of the date of failure. Remain employed without reducing your hours or quitting unless you have good cause.
- Apply for and seek employment and accept any reasonable offer to suitable employment.

YOUR OPPORTUNITIES

- Based on your activity and the availability of funding, you may receive help paying for support services (transportation) in order to find employment, education, or other assigned activity(ies), unless you are able to make these arrangements on your own.
- You have the opportunity to have decisions about your case reviewed by a supervisor and request a hearing if you disagree with a decision.

YOUR ACCOUNTABILITY

- I will be required to complete a minimum of 20 hours of weekly activities
- I understand that it must be submitted on a weekly basis unless stated otherwise by a Career Advisor.

CONSEQUENCES FOR FAILURE TO PARTICIPATE

SNAP PENALTIES

1st Penalty: FOOD STAMP penalties may be imposed for one month or until compliance, whichever is longer.

2nd Penalty: FOOD STAMP penalties may be imposed for 3 months or until compliance, whichever is longer.

3rd Penalty: FOOD STAMP penalties may be imposed for 6 months or until compliance, whichever is longer.

X _____ _____

Participant's Signature Date

_____ _____

Name of Physician Date

Dear Physician,

I, _____, am requesting that the attached Medical Verification form be completed.

In order to receive temporary cash assistance and prepare individuals and families for self-sufficiency, individuals receiving cash assistance are required to participate in countable work activities. Additionally, Florida limits such families to receive cash assistance for a total of 48 months. Some participants may receive a medical deferral as a result of an injury, a temporary medical condition, or other good cause reason. However, if a participant is in deferred status, he/she continues to be subject to the cash assistance time limits.

- I am requesting that my medical information be released to the Welfare Transition Program provider to help me develop my self-sufficiency plan. To become self-sufficient, I will work with my career manager to overcome barriers to employment and/or seek medical/disability services.
- My self-sufficiency plan may include participation in medical treatment, counseling, therapy, etc.
- My plan may include employment, attending classes, studying at home, or volunteering at a worksite designed to meet my physical/mental health limitations.
- Each time a new form is needed, *I will sign a request for medical information authorizing the licensed physician to complete the form.*
- The participant or legal guardian for participants under the age of 18 are the only representatives allowed to provide consent/request for information on the medical verification form.
- **The release of medical information portion of the medical verification form is located on the next page.** The release of medical information verifies that I have reviewed my rights and responsibilities regarding the release of my confidential health information with my career manager. **The release includes my rights and responsibilities as stated in the Health Insurance Portability and Accountability Act (HIPAA).**

Thank you for taking the time to complete the medical verification form. Please forward the completed form to my career manager at the below address/fax number. If you prefer, you can release the paperwork back to me, and I can deliver the paperwork myself.

Name: **Phone Number:**
Address: **Fax Number:**

Release of Medical Information

Participant's Name: **Social Security Number:**

Birth date:

I understand that I have given the physician permission to complete the medical verification form.

- I understand that the information will state my current diagnosis and possible limitations to engage in countable work activities. By completing the medical form, I am requesting that my physician provide the information to the Welfare Transition Program (WTP) provider.
- The information on the form will be used to develop a personalized self-sufficiency plan that takes my limitations, medical needs and treatment into consideration. The completed form may also be used when considering an extension to my cash assistance time limits.

Rights

- I have the right to refuse to sign the Release of Medical Information Form. Refusing to sign the form (**alone**) will not affect my benefits.
- The authorization of the Medical Verification Form may not condition medical treatment, payment, or enrollment.
- I understand that I have the right to revoke the authorization of this form. To revoke the authorization, **I must submit a request in writing to both the physician and the WTP provider. I will have to provide the written request to both parties by the close of business (5 p.m.) on _____/_____/_____.**
- Once the form is completed, the form will be included in my case file, but the information may not be used to determine limitations or medical inability after six months from the physician's signature date.
- I have the right to privacy. The medical verification form and information that is given in the form is confidential health information. The WTP provider is the sole recipient of the information. The information may be disclosed only in the course of official business and the verification of continued eligibility/compliance.

Responsibilities

- I have agreed to have the form completed and return the completed form to my career manager by (*date*)_____ at (*time*)_____.
- **If I refuse to sign the form or fail to supply the required information by the above date**, I **must** participate in the Welfare Transition Program's (WTP) countable activities for the minimum required hours unless another good cause reason is documented.
- I **must** complete the activities as indicated on my self-sufficiency plan. **Refusal to sign the form and failure to participate in countable activities may result in the reduction or cancellation of my cash assistance and food assistance benefits.**
- **If I refuse to participate in the program and fail to complete the agreed upon activities listed in my self-sufficiency plan, my benefits may be reduced or cancelled.**
- If the form is revoked, I am still responsible for completing the activities I agreed to complete on my self-sufficiency plan.

I have reviewed my rights and responsibilities with my career manager.

_____ _____ Expiration of Request is 60 days from signature date.

Signature of Participant Date of Signature

_____ _____ _____

Signature of Guardian if under 18 years of age Printed Name of Guardian Date

MEDICAL VERIFICATION FORM TO BE COMPLETED BY LISCENSED PHYSICIAN

Name of Participant: **Social Security Number:**

1. What is the specific diagnosis of illness/injury of the participant? _____

2. A participant **may still be able to work** with limitations **or be assigned to an activity** that requires little physical strain or demand (attending classes, volunteer, home study, answering telephones, filing while seated).

WORK

a) Can (s)he "work" sitting down? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted _____

b) Can (s)he "work" standing up? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted _____

c) Are there other restrictions to him/her working? ☐ Yes ☐ No

Restrictions: _____

d) Are the number of hours (s)he can "work" limited? ☐ Yes ☐ No

☐ 1-10 hours ☐ 11-20 hours ☐ 21-30 hours ☐ 31-40 hours a week **or** ☐ Unable to "work" at all

VOLUNTEER

e) Can the (s)he volunteer hours? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted _____

Other limitations: _____

SCHOOL

f) Can the (s)he go to school or go to classes? ☐ Yes ☐ No Comments:_____

Are there limitations? _____

3. Is this condition ☐ permanent or ☐ temporary? If temporary, indicate estimated duration _____# Months. If this individual is pregnant, what is the expected date of delivery? _____/_____/_____.

4. Is (s)he required to attend physical therapy? ☐ Yes ☐ No If yes, how often? _____

5. Is (s)he required to attend counseling appointments? ☐ Yes ☐ No If yes, how often? _____

6. Is (s)he required to attend any other type of therapy or regular appointments? ☐ Yes ☐ No If yes, how often? _____

7. Date of patient's most recent office visit: _____/_____/___

_____ _____ (____) ____-_____

Name of Licensed Physician **Signature of Physician: this form must be signed by a *Licensed* Physician.** **Telephone Number**

_____

Mailing Address (include city and zip code)

_____ _____/_____/_____

Physician's License Number (per Chapter 458 or Chapter 459, F.S.) **Date Form Completed**

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

DEO-WTP 2288(a), March 2013 (Replaces DEO-WTP 2288(a), October 2011)
Includes HIPPA language and requirements

WELFARE TRANSITION PROGRAM

VOLUNTARY PARTICIPATION FORM

This is to state that I am fully aware that I have been Medically Deferred from participation in the work activity portion of the Welfare Transition / SNAP Program and that I may not fully participate in back to work activities without my Doctor's approval.

However, I am voluntarily agreeing to participate by signing this document. I understand this document must also be signed by my Doctor.

I understand that my participation in the work activities assigned on my IRP and Steps to Self-Sufficiency is mandatory.

I also understand that if I do not participate, I will be sanctioned for non-compliance.

\ \

PARTICIPANT'S SIGNATURE **Last 4 S.S. #** **DATE**

\

CAREER ADVISOR'S SIGNATURE **DATE**

\ \

LICENSED PHYSICIAN SIGNATURE **LICENSE #** **DATE**

WORK EXPERIENCE REFERRAL
WORK SCHEDULE

EMPLOYMENT & TRAINING OPPORTUNITY PROGRAM
6913 NORTH 9th AVENUE
PENSACOLA, FL 32504

Participant Name: _____ **RFA#: _____**

Required Number of Hours per Week: _____ **Start Date: _____**

Career Advisor: _____

Worksite:_____ **Site Supervisor: _____**

EMPLOYER INSTRUCTIONS:

1. **Conduct Interview to approve or disapprove.**
2. **If approved, fill in Worksite, Site Supervisor, and work schedule below based on your business needs and the number of hours the participant needs listed above.**
3. **The start date is the latest date that the participant must start at your worksite.**
4. **Please sign and date form, and return to the participant.**
5. **If you have any questions, please call 850-607-8800.**

WORK DAY	TIME IN	LUNCH		TIME OUT	Total Hrs. Scheduled
		Out	In		
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					
				TOTAL SCHEDULED EACH WEEK	

Participant Signature: _____ **Date:** _____

Site Supervisor: _____ **Date:** _____

CA Signature: _____ **Date:** _____

WT/SNAP Weekly Activities Time Sheet

Name: _____ Last 4 SSN#: _____ Career Advisor: _____

Week Of: _____ Employment YES or NO: _____ Hourly Wage:_____

I understand that CareerSource Escarosa is intended to educate and assist individuals in the attainment of employment. Submitting this form to the WT/SNAP program office is an affirmation that the following activities have been completed. I must continue with these activities each weekday until I am directed not to do so by my Career Advisor. I must follow through on job leads and work with CareerSource Escarosa staff to improve my opportunities of finding a job. This timesheet must be submitted to CareerSource Escarosa by 1:00pm each Monday.

Fax: Pensacola (850) 607-8851 – Milton (850) 983-5330 – Century (850) 366-4015

Date	Type of Activity or Name of Class	Time In:	Time Out:	Time In:	Time Out:	Total Hrs: (completed by WT/SNAP Staff Only)	Supervisor or Instructor Signature:

(For WT/SNAP Use Only)

For Official Use Only:	JPR Week Being Verified:		Hours Credited:		Career Advisor Signature:	

Participant Signature: _____ Date: _____

WT/SNAP External Job Search Log

Name: _____ Last 4 SSN#: _____ Career Advisor: _____

Submitting this form to the WT/SNAP program office is an affirmation that an active job search to the following employers has been completed. You will receive 1 hour of job search credit for each completely filled out contact.

PLEASE PRINT in BLUE OR BLACK INK **This Job Search will be randomly verified and must be completed with a pen.**

Date of Job Search:____/____/____			
	Business Name	**Street Address or Website**	**Position**
1			
2			
3			
4			
5			
6			
7			

(For WT/SNAP Use Only)

For Official Use Only:	JPR Week Being Verified:		Hours Credited:		Career Advisor Signature:	

Participant Signature: _____ Date of Submission: _____

Verification of School Enrollment

NAME: _____ Last 4 digits SS# _____

DATE: _____

In order to continue education as your primary activity, you must have the following information completed and returned to our office.

Educational Facility: _____

Program Title: _____

Length of Program: _____

Beginning Date: _____

Anticipated Completion Date: _____

School Official Signature: _____

Title: _____

Phone Number: _____

Date Completed: _____

_____

Participant Signature

CareerSource Escarosa

PROGRESS VERIFICATION AND AUTHORIZED SCHOOL REPRESENTATIVE SIGNATURES

The listed participant is in an education and training program offered by CareerSource Escarosa. For this participant to be successful in your class please advise the following:

How many hours of supervised study time are required for satisfactory completion of your class each week? _____

How many hours of unsupervised study time are required for satisfactory completion of your class each week? _____

TOTAL HOURS _____

Student Name: _____ School Term Dates: _____

CareerSource Escarosa must have a list on file of ALL staff members who are authorized to sign Weekly Attendance and Progress Verifications. Please List all authorized management and professors/teachers who can sign off on Weekly Attendance sheet. We need to have signatures on file to compare to signatures on faxes/ submitted time sheets.

NAME (PLEASE PRINT) **SIGNATURE**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

THANK YOU!!

UNDERSTANDING OF VOCATION EDUCATION AND TRAINING POLICY STATEMENT

I understand that all requests for Vocational Training must be approved by my Career Advisor. I am currently enrolled in or I am in the process of enrolling in Education or Training at an institution for higher education or learning and I understand I must provide the following documents to my Career Advisor for consideration:

a. School Enrollment Verification Form
b. Copy of Class Schedule
c. Authorized school representative signatures and study hour form
d. Copy of Course Syllabus
e. School Academic Plan
f. Other documentation - i.e. transcripts of all prior education and training for ANY education or training program of 1 year or longer.

I understand that the program or course of instruction must be listed on the WT approved list of training to be eligible for support services and monetary incentives.

I understand the education or training will count as my primary activity for no more than a total of 12 months of my lifetime benefit. That any portion of a month will count as a full month.

I understand that if I am enrolled in the Vocational Education and Training program and do not complete the training in 12 months, I will be transferred to work experience and education will become my Core Plus (secondary) activity.

I understand that if my chosen program is more than 1 yr and is not on the approved WIA training list I will NOT receive any support services or monetary incentives.

I understand that any remedial classes that I may have to take will NOT count as Vocational Education. I will be assigned to ETOP and remedial classes may count as Job Skills Training.

I understand I will be required to turn in a ETOP Time sheet and/or a Weekly Attendance and Progress Verification sheet every week by the due date and time.

I understand I must obtain instructor signatures verifying satisfactory progress for education hours to count.

_____ _____

Print Participate Name **Participant Signature and date**

_____

Career Advisor signature and date

CareerSource ESCAROSA

WELFARE TRANSITION AND SNAP PROGRAMS
WORK SITE JOB SKILLS TRAINING (JST) OUTLINE

1. Work Site Name/ Address: _____

_____

2. Work Site Phone#/Contact Name _____
3. Work Site Hours _____ Work Site Days _____
4. Job Title: _____
5. Trainee Name: _____
6. Start Date: _____ Start Time _____
7. JST Hours Per Week: _____
8. Length of Training: _____

JST Training Activities:

Employer's Policies and Procedures
Using online resources, work on improving typing speed and accuracy
Work on improving proficiency in Microsoft Office Suite using www.gcflearnfree.com

_____
Participant's Signature

_____ _____
Authorized Work Site Representative ETOP Representative

As the authorized work site representative, I understand that only ETOP and/or Internship hours are covered by Workers Compensation Insurance provided by the State of Florida. Any incident that occurs during JST hours would be covered solely by the participant's Medicaid Insurance.

Received: _____
By: _____
Contact Date: _____
Phone: _____ Letter ____In Person____
Appt. Scheduled: _____

FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
REFERRAL/APPLICATION FOR VOCATIONAL REHABILITATION SERVICES

I am a person with a mental or physical impairment that interferes with my ability to work. I want to learn more about the rehabilitation services available through the Division of Vocational Rehabilitation and how they can assist in securing or retaining employment.

Name: __ _____

Social Security Number: _____ Date of Request: _____

Address: _____

City, State Zip: _____, ___FL___, _____

Date of Birth: _____ Sex: ____

Marital Status: _____ Race: ____ Education Level: _____

Telephone number where you can be reached: _____ _____

Or email address (if preferred):_____

Name of a contact person: _____

Telephone number of the contact person: _____ _____

What is the best method to contact you? _____

What impairment prevents you from working: _____

_____

Do you require American Sign Language interpreter? ☐ Yes
Do you require assistive listening device? ☐ Yes
Do you require a foreign language interpreter? ☐ Yes If so, which language: _____
Do you require any accommodation for your impairment? ☐ Yes
If yes, please explain: _____

_____

If referral is by an agency or other person:
Name: _____
Address of Agency or Person _____
City, State, Zip-Code: _____, _____, _____
Telephone Number: _____ _____

(Your signature, or that of your parent or guardian, completes the application process for Vocational Rehabilitation. You may request additional information or speak with a counselor to get information prior to application.)

I understand that the purpose of receiving vocational rehabilitation services is to enable me to retain or secure employment. I understand that I must be found eligible for the services that I require. I am applying for vocational rehabilitation services and wish to undergo an assessment of my eligibility.

_____ _____
Signature of Applicant Date of Application

_____
Signature of Parent or Guardian

Please mail or turn in your applicat
ion to the nearest DVR office.
For a list of offices, go to: www.rehabworks.org and then click on:
"Contact Us" and then select "Directory of Local VR Offices and Vendors"
OR
You may call our toll free number 1-800-451-4327 for more information.

Florida Department of Education Division of Vocational Rehabilitation Social Security Number Collection Policy

In compliance with Section 119.071(5), Florida Statutes, this statement serves to notify you of the purpose for the collection and usage of your social security number by the Florida Department of Education, Division of Vocational Rehabilitation ("Division").

The Division is authorized by federal and state law to collect social security numbers in determining individuals' eligibility for vocational rehabilitation services, and such collection is imperative for the performance of the Division's duties.

Information about Discrimination

It is against the law for the Division of Vocational Rehabilitation (DVR) of the Florida Department of Education, as a recipient of Federal financial assistance, to discriminate against any individual in the United States on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief.

The application process used by DVR to determine eligibility for services, any subsequent services, and the entire DVR process are subject to these non-discrimination requirements.

What to Do If You Believe You Have Experienced Discrimination

If you think that you have been subjected to discrimination under a federally assisted program administered by the Division of Vocational Rehabilitation, you may file a complaint within 180 days from the date of the alleged violation with either:

Florida Department of Education
Division of Vocational Rehabilitation
Ombudsman Section
2002 Old St. Augustine Road, Building A
Tallahassee, Florida 32301-4862
Phone: (800) 451-4327 (Voice/TDD)

OR

U.S. Department of Education
Office for Civil Rights (OCR)
Atlanta Office
61 Forsyth Street
Suite 19-T-70
Atlanta, Georgia 30303-3104
Phone: (404) 562-6350
TDD: (877) 521-2172
e-mail: OCR.Atlanta@ed.gov

Substance Abuse and Mental Health (SAMH) Treatment Verification

CONFIDENTIAL SENSITIVE INFORMATION - MUST BE KEPT LOCKED WHEN NOT IN USE.

Section A:

_____ _____ _____/_____/_____

Participant Name | Social Security Number | Date

_____ _____

Regional Workforce Board (RWB) Designee | Public Assistance Specialist (PAS)

RWB/PAS Address:_____ RWB/PAS Region _____

_____ RWB/PAS Fax #: _____

_____ _____ _____

SAMH Provider Agency | Telephone Number | Fax Number

Section B: ***Limited Work Exception for Non-Medical Incapacity Treatment Verification***

The participant above is currently participating in a treatment program. The participant has completed_____hours of treatment during the past month, for the following weeks:

Week 1:____/____/____-_____/____/____for_____hours. Week 2:____/____/____-_____/____/____for_____hours.

Week 3:____/____/____-_____/____/____for_____hours. Week 4:____/____/____-_____/____/____for_____hours.

The participant's total hours of completion in the treatment program during the past 12 months are_____hours.

_____ _____ _____/_____/_____

Name and Credentials of SAMH Counselor/Case Manager | Telephone Number | Date

Section C: ***Completion of Treatment Verification***

The participant indicated above has successfully completed a Mental Health / Substance Abuse Treatment Program. The months in which the participant fully complied with the treatment requirements are circled below, totaling_____months in a(n)

_____program.

20____: January February March April May June July August September October November December

20____: January February March April May June July August September October November December

_____ _____

Name and Credentials of SAMH Counselor/Case Manager | Telephone Number | _____/_____/_____ Date

Section D: ***Public Assistance Specialist Verification of Treatment Months and Receipt of Temporary Cash Assistance***

The number of months verified and approved for an extension to the participant's time limit are_____months.

_____ _____ _____/_____/_____

Public Assistance Specialist | Telephone Number | Date

Section E: ***Understanding Extension Treatment Months***

I understand that my time limit has been extended_____months due to my completion of the SAMH treatment program.

_____ _____/_____/_____

Participant Signature | Date

_____ _____ _____/_____/_____

Regional Workforce Board Designee | Telephone Number | Date

Comments: _____

_____

For Official Use: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and Chapters 394 and 397, Florida Statutes. The federal and state rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2 and Chapters 394 and 397, F.S. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal and state rules restrict any use of the information to criminally investigate or prosecute any substance abuse/mental health participant.

SAMH Treatment Verification Instructions

The purpose for this form is to cover the legislative mandates added to Chapter 414, Florida Statutes this year regarding mental health and/or substance abuse treatment for those receiving temporary cash assistance. This form is designed to provide the treatment verification for both the limited exception from work activity for non-medical incapacity treatment and completion of treatment.

Section 414.065(4)(e), F.S., Noncompliance related to outpatient mental health and substance abuse treatment. If an individual cannot participate in the required hours of work activity due to a need to become or remain involved in outpatient mental health or substance abuse counseling or treatment, the individual may be exempted from work activity up to 5 hours per week, not to exceed 100 hours per year. An individual may not be excused from a work activity unless a mental health or substance abuse professional recognized by the Department or Regional Workforce Board certifies the treatment protocol and provided verification of attendance at the counseling or treatment sessions each week.

Section 414.105(3), F.S. A TCA recipient who is not exempt from work activity requirements and who participates in a recommended mental health or substance abuse treatment program may earn one-month of eligibility for extended temporary cash assistance, up to a maximum of 12 additional months, for each month in which the individual fully complies with the requirements of the treatment program. This treatment credit may be awarded only upon successful completion of the treatment program and only once during the 48-month time limit.

Section A

This section is the confidential demographic information that is used to transfer treatment verifications through different correspondence channels. The form originates at the SAMH treatment provider agency and information is transmitted to the Regional Workforce Board (RWB) designee for Section B during outpatient (non-residential treatment levels) and Section C at the completion of treatment for all treatment levels. The names of the RWB designees and Public Assistance Specialists (PAS) are provided by the TANF SAMH participants who need to investigate who their contact persons are if they don't already know as part of becoming economically self-sufficient.

Section B

This section is for verification of treatment to be forwarded to the RWB designee by the SAMH counselor/case manager on a weekly, bi-weekly or monthly basis. The number of hours that the TANF SAMH client participates in "non-medical incapacity" treatment to assist with work activity completion may not exceed 5 hours a week, and 100 hours in any 12 month period. This is known as limited work exception activity and can be used as "good cause" for not working up to the required work activity hours assigned. Should more treatment hours be indicated, a physician's approval for "Medical Incapacity" is required for any level of care.

Section C

This section is for verification of successful completion of treatment of the TANF SAMH participant by a mental health/substance abuse treatment program director as provided in s. 414.105(3), F.S. The months in which the participant fully complied with the treatment requirements are circled and sent to the RWB designee for credit towards each month of eligibility for temporary cash assistance, up to 12 months within the 48-month time limit.

Section D

The RWB designee makes note of the update and sends the circled months to the TANF SAMH participant's PAS for verification that the person was indeed receiving temporary cash assistance during those same months. The PAS then approves/disapproves the extension to the participant's time limit based on the participant's eligibility status during the circled months and send it back to the RWB designee. The PAS will update the ARCA screen to include the number of months being credited.

Section E

The RWB designee reviews the PAS' successful treatment completion credit extension approval/disapproval with the participant and the participant signs a statement of understanding.

CareerSource ESCAROSA

Weekly Counseling Session Attendance

Employee Name: _____ **RFA#:** _____

Counseling Facility: _____ **Career Advisor:** _____

Week Starting: _____

Must be submitted to CareerSource Escarosa by 1:00 pm each Monday
Fax: (850) 607-8851

Day of Week	Date	Time In	Time Out	Total Time	Counselor's Signature
Sun					
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					

Weekly Total: _____

_____

Participant's Signature **Date**

CareerSource ESCAROSA

Welfare Transition Program
Steps to Compliance

NAME: _____ FULL SOCIAL SECURITY # _____

DATE: _____ RFA# _____

I am requesting that my sanction be lifted for the following reason (check one)

☐ To receive cash assistance and participate in the WT program

☐ To receive food stamps only. I do not wish to participate in the WT program **(complete the attached OPT OUT request)**

Upon returning to the WT program, I agree to follow the steps listed and to complete all activities and responsibilities assigned to me. My opportunities and obligations as a Welfare Transition participant have been explained to me. I have received a copy of these opportunities and obligations, and I understand them.

By signing below, I acknowledge that if I do not complete the following activities my ***sanction will not be lifted*** and will not be signed by the WT Intake staff.

Step 1	**Description**
	• Complete attached WT Compliance Packet, Opportunities and obligations
Step 2	**Description**
	• **Completed Workshops** • **Submit copies of 5 completed job applications** **or** • **Turn in social security documentation in place of above job search requirements** • **Crib card/birth certificate** • **Need for Care Form** • **Verification of employment** • **Verification of school enrollment with class schedule**
Step 3	**Description**
	• Submit completed questionnaire

_____

Participant Signature

_____ _____

Verified by: Employee Signature **Sanction Level**

Opt-Out Statement

Date:

This letter is submitted to inform Department of Children and Families (DCF) that I, _____, RFA# _____ wish to withdraw my TANF application. I wish to continue to receive my Food Stamp and Medicaid benefits.

Due to the fact that I received TANF assistance for the month of _____, I am still required to complete all of my CareerSource Escarosa assigned work activity (ies) until DCF updates my AGPI status and my case is closed.

I acknowledge the fact that by signing below, I will complete my work activity(ies) until directed otherwise and failure to do so will result in an ***immediate withdrawal*** *of this 'Opt-out statement' and an* ***adverse action will be requested*** *which may affect my Food Stamp benefits, as determined by DCF. It has been recommended to me to call DCF to request that* ***I do not want cash for the next month.***

Participant Name **RFA #**

Participant Signature

Career Advisor Signature **Date**

WT Compliance Packet

Participant Name: _____

Today's Date: _____ RFA: _____

Complete this form in its entirety. Answer all questions and turn it in to the WT Intake staff. The assessment form will be reviewed for completeness. Once you are approved for cash assistance it will be discussed in further detail with your assigned Career Advisor. The information you provide to us is confidential and will be used in development of your **Career Plan.** Your Career Plan will determine your goals, the need for support services and the appropriate activity assignments.

Section 1 – Customer Information

Mailing Address: _____

_____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Email Address: _____

Ethnic Origin/Race (for statistical purposes only not to be used for screening)

☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Hawaiian Pacific ☐ Other: _____

Date of Birth: _____ Sex: _____

Section 2 – Needs Assessment

Children in the Household	**Age**			
_____	_____	In School?	☐ Yes	☐No
_____	_____	In School?	☐ Yes	☐ No
_____	_____	In School?	☐Yes	☐ No
_____	_____	In School?	☐ Yes	☐ No
_____	_____	In School?	☐ Yes	☐ No

BARRIERS TO EMPLOYMENT:

☐ Transportation ☐ Child Care Needed ☐ Criminal Record

Comments: _____

_____

Other Barrier: _____

_____

CareerSource ESCAROSA

SANCTION LIFT QUESTIONS

1. **Why did you apply for TANF (welfare)?**
2. **How many months can you receive TANF in a lifetime?**
3. **What does "your participation is Mandatory, and you are required to complete all assigned activities" mean to you?**
4. **How many times have you received a sanction?**
5. **What caused you to receive a sanction on your case?**
6. **What will you do differently to prevent another sanction?**
7. **List 5 things that will make sure you succeed and obtain employment**
8. **How many hours are you required to complete every week to in the WT program?**
9. **What do you hope to receive from successfully completing the WT program?**
10. **Are you looking for a job?**
11. **How many weeks will it take you to find a job?**
12. **What type of job are you looking for? - Be specific: housekeeping, receptionist, admin, Cashier, sales**
13. **When did you last apply for a job?**
14. **Where did you last apply for a job?**
15. **Did you complete and submit an application or submit a resume?**
16. **Have you ever been assigned to ETOP (work hours) in the WT program?**
17. **Where were you assigned to complete your hours?**

18. **Were you assigned to more than one site?**

19. **What were the other sites?**

20. **What did you do there?**

21. **Can you use the supervisors or managers at that site or any site as a work reference?**

22. **If not, why not?**

23. **Do you have any other work or professional references that will vouch for your work ethic or dependability?**

24. **Do you have a GED or Diploma?**

25. **If not, then tell us why you have not yet received your GED?**

26. **How long will it take you to get your GED?**

27. **List your employment and/or career goals?**

28. **Would you like to go back to school to gain a better paying job and begin a career?**

29. **What do you see yourself accomplishing with your career goals in the next 1 - 2 years?**

Supplemental Nutrition Assistance Program (SNAP)
Steps to Compliance

NAME: _____ FULL SOCIAL SECURITY # _____

DATE: _____ RFA# _____

Upon returning to the SNAP program, I agree to follow the steps listed and to complete all activities and responsibilities assigned to me. My opportunities and obligations as a SNAP participant have been explained to me. I have received a copy of these opportunities and obligations, and I understand them.

By signing below, I acknowledge that if I do not complete the following activities my ***sanction will not be lifted*** and will not be signed by the SNAP Intake staff.

Step 1	**Description**
	• Complete attached SNAP Compliance Packet, Opportunities and obligations
Step 2	**Description**
	• **Submit copies of 5 completed job applications** **Or** • **Need for Care Form** • **Verification of employment** • **Verification of School (must be at least half-time student)** • **Medical Documentation from Physician stating unable to work** • **SSI/SSDI approval**

_____
Participant Signature

_____ _____
Verified by: Employee Signature **Sanction Level**

Return On or After: _____

CareerSource Escarosa
Supplemental Nutrition Assistance Program (SNAP)

OPPORTUNITIES AND OBLIGATIONS

YOUR OBLIGATIONS

- You are required to participate in and complete all assigned program activities.
- Respond to all contacts from SNAP associates.
- Inform your SNAP Career Advisor of changes in participation, employment, family circumstances, including change of address, telephone number, children, transportation problems, health problems, etc.
- Good cause reasons for failure to participate must be reported within three working days of the date of failure. Remain employed without reducing your hours or quitting unless you have good cause.
- Apply for and seek employment and accept any reasonable offer to suitable employment.

YOUR OPPORTUNITIES

- Based on your activity and the availability of funding, receive help paying for support services (transportation) in order to find employment, education, or other assigned activity (ies), unless you are able to make these arrangements on your own.
- You have the opportunity to have decisions about your case reviewed by a supervisor and request a hearing if you disagree with a decision.

YOUR ACCOUNTABILITY

- I will be required to complete 20 hours of weekly activities
- I understand that it must be submitted on a monthly basis unless stated otherwise by a Career Advisor.

CONSEQUENCES FOR FAILURE TO PARTICIPATE

SNAP PENALTIES

1st Penalty: FOOD STAMP penalties may be imposed for one month or until compliance, whichever is longer.
2nd Penalty: FOOD STAMP penalties may be imposed for 3 months or until compliance, whichever is longer.
3rd Penalty: FOOD STAMP penalties may be imposed for 6 months or until compliance, whichever is longer.

_____
Participant Name

_____ _____
Participant Signature Date

Supplemental Nutrition Assistance Program (SNAP)
Compliance Packet

Participant Name: _____ Social Security# _____
Today's Date: _____ RFA: _____

Complete this form in its entirety. Answer all questions and turn it in to the SNAP Intake staff. The information you provide to us is confidential and will be used in development of your **Career Plan.** Your Career Plan will determine your goals, the need for support services and the appropriate activity assignments.

Customer Information

Mailing Address: _____

_____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Email Address: _____

Ethnic Origin/Race (for statistical purposes only not to be used for screening)

☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Hawaiian Pacific ☐ Other: _____

Date of Birth: _____ Sex: _____

Opt-Out Statement

Date: _

This letter is submitted to inform Department of Children and Families (DCF) that I, _____ , RFA number _____ wish to withdraw my TANF application. I wish to continue to receive my Food Stamp and Medicaid benefits.

Due to the fact that I received TANF assistance for the month of _____, I am still required to complete all of my CareerSource Escarosa assigned work activity (ies) until DCF updates my AGPI status and my case is closed.

I acknowledge the fact that by signing below, I will complete my work activity(ies) until directed otherwise and failure to do so will result in an ***immediate withdrawal*** *of this 'Opt-out statement' and an* ***adverse action will be requested*** *which may affect my Food Stamp benefits, as determined by DCF. It has been recommended to me to call DCF to request that* ***I do not want cash for the next month.***

Participant Name **RFA #**

Participant Signature

Career Advisor Signature **Date**

DO NOT WRITE ON THIS FORM

Child Care Application and Authorization

Authorization ☐ INITIAL AUTHORIZATION ☐ REDETERMINATION ☐ UPDATE

If UPDATE, change in: ☐ Hours ☐ Children ☐ Address ☐ Custody ☐ Eligibility Extension ☐ Other

Name of Staff initiating Referral: (Print) ☐ Coordinating Agency ☐ DCF ☐ Welfare Transition Contracted Provider ☐ Privatization Provider

Unit, Number & Address:

City, Zip Code | Phone #:

SECTION A: CLIENT/FAMILY INFORMATION

(Print name, SSN, Date of Birth and Gender. Check appropriate box indicating ethnicity and race, enter letter designation for each race indicated by participant. i.e., (W) White, (B) Black, (A) Asian, (H) Hawaiian and (AI) American Indian. (Use comma to separated each race, i.e., B,A and AI)

RFA #:

Parent/Guardian/Foster Parent/Caregiver Name: (L,F,MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	
Spouse's Name: (L,F.MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

If there is NO spouse: enter the Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Parent/ (if different from above): (L,F,MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

SECTION B: ELIGIBILITY

I. Status: ☐ **Assistance** ☐ **Non-Assistance**

☐ **At Risk**: ○ PI ○ PS ○ FS ☐ **Project Safety Net**

☐ In Home ☐ Out of Home: Relative/Non-Relative ☐ Foster Care

☐ **TCA**	☐ **Transitional**	☐ Applicant	**X** Recipient
☐ Respite	☐ Unemployed Parent	☐ Refugee	
☐ **TCC**	☐ Transitional Education & Training	**TCC Begin Date:**	**TCC End**

II. Purpose of Care

☐ Protection ☐ Therapeutic Plan ☐ TANF At Risk (RCG) ☐ Emergency

☐ Employment ☐ Work Activity ☐ Education Activity

SECTION C: CHILD CARE AUTHORIZATION (Print Legal names of children authorized for care)

Child care service is authorized for the participant for approved activity(ies) not to exceed a total of ____ hours per week and includes ____ hours transportation time.

Name (F,MI,L)	SSN	DOB (MM/DD/YY)	Gender(M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	

Gross Monthly Family Income: $ TANF: -- FS: -- Attach Documentation (if available)

CHILD CARE AUTHORIZED From Through

Comments:

SECTION D: AUTHORIZING SIGNATURE(S) certifying accuracy of information.

Applicant Signature: Date:

Authorizing Staff Signature: Date:

Supervisor's Signature: Date:

Coordinating Agency: Date:

*****THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE*****

THIS DOCUMENTATION CONTAINS CONFIDENTIAL INFORMATION AND IS PROTECTED BY LAW. IT IS INTENDED FOR USE BY AUTHORIZED USERS ONLY AND WILL BE KEPT AS A PART OF PARTICIPANT'S RECORDS. IT IS NOT FOR PUBLIC DISSEMINATION*

Name (F,MI,L)	SSN	DOB (MM/DD/YY)	Gender(M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	

Welfare Transition Program
Acceptance of Child Care Assistance

NAME: _____

DATE: _____ RFA# _____

By choosing to apply for Temporary Cash Assistance, I understand that I have been referred to the Welfare Transition Program and will be immediately assigned to a work activity for a minimum of 35 hours per week. The Welfare Transition Program will provide child care assistance so that these activities can be completed.

By signing below, I acknowledge to the following:

1) Participation in the Welfare Transition Program is a ***mandatory*** requirement for receiving Temporary Cash Assistance and I will be required to complete a minimum of 35 hours per week of work activities.

2) I have received a child care referral. This referral must be presented to Early Learning Coalition during my scheduled appointment.

3) I have received a "What to Bring for Enrollment" and must have all the required documentation necessary to establish child care when I attend walk in hours at Early Learning Coalition.

4) I must have child care in place before attending my next scheduled appointment with the Welfare Transition Program.

_____ _____

Staff Signature **Participant Signature**

Early Leaming Coalition •I WaminaComy

WHAT TO BRING FOR YOUR APPOINTMENT

crrr:c er Early Learning
LEARN EARLY. LEARN FOR LIFE.

For the purpose of determining eligibility for school readiness services, the following documents are required. The enrollment process cannot be complete without all applicable documents. If you fail to provide all necessary documentation the enrollment for your child/children will be delayed and you may be asked to apply for the Waiting List.
If a document is not available to you, please discuss possible solutions to the problem with the Eligibility Specialist.

Documents for Identification:

- Florida Picture I.D. / Driver's License
- Proof of residency in Escambia County (lease, utility bill, voter's card etc.) (If no utility bill is in your name, bring a notarized statement from the person you are living with and a copy of their utility bill)
- Social Security cards for parent/guardian and all children
- Birth Certificates for all children in household (needing services or not)
- Copies of separation or divorce papers, if applicable
- Copies of custody agreements or proof of guardianshi p, if applicable

Administrative Documents:

- Food Stamp verification-REQUI RED DOCUMENTATION (DCF Notice of Case Action eligibility letter)
- Public Housing verification
- School Class Schedule- MUST SHOW CREDIT HOURS BEING TAKEN
- Referral from Workforce, DCF, or Families First Network, if applicable

Financial Eligibility:

- Proof of Employment- Last 6 weeks of pay stubs for all adult household members.
  (Example: 6 weekly, 3 bi-weekly. 4 semi-monthly, or 2 monthly pay stubs)
  If you do not receive pay stubs, you can bring an employer statement on company letterhead for each adult household member verifying payroll history for the past 6 weeks including: gross wages, net wages and numbers of hours worked for each pay period.
- Self-Employment- All business records must be made available to Eligibility Specialist
  - Work calendars/business ledger for pay received, tips received and hours worked
  - **Income tax return**
  - Receipts for expenses related to operation of business
- Child Support – For court ordered child support must obtain a printout from the Department of Juvenile Justice and must include the last six (6) weeks of payment history. For non court ordered child support. a written statement from absent parent stating what has been paid over the last 6 weeks
- Verification of Additional Income, which may include:
  - Social Security
  - Unemployment Benefits
  - Supplemental Income (SSI)
  - Relative Caregiver Program Benefits
  - Public Assistance (TANF)
  - Any other household income received
- Verification of disability if unable to work, must include current SSA award letter and statement from licensed physician stating you are permanently/temporarily disabled. If temporarily disabled, letter must state expected duration of temporary disability
- If you do not have your Child Care Provider Selected, please contact Child Care Resource and Referral at 850-595-5915.

Please call (850) 332-6775 for an appointment.

ELC School Readiness Services
3300 N Pace Blvd, Suite 210, Pensacola, FL 32505
Tel: (850) 332-6775 · Fax: (850) 466-3783

NOTICE OF CHANGE IN CHILD CARE STATUS

TO:	Date Mailed:
	RFA #:
	SSN:

SECTION A: Your child care is being: ☐ terminated ☐ denied ☐ needs to be redetermined.
You may be eligible to receive continued child care. Contact the child care agency for more information.

Your last day of child care services will be _____ because of the following:

☐ 1. You are no longer eligible for child care for the following reason: _____.

☐ 2. You failed to provide _____ needed to verify your eligibility. If you want your child care to continue, you must provide the items above before your last day of services.

☐ 3. Your authorization ends on the above date, if you want child care to continue please contact _____.

☐ 4. You may be eligible for transitional child care (TCC). Please contact the Department of Children and Families Public Assistance Specialist or the RWB Provider for information on TCC.

☐ 5. Non-payment of parent fees.

☐ 6. Continuation of your child care services needs to be reviewed.

☐ 7. Your child care provider failed to complete the required 3 hour training.

☐ 8. Your child care provider failed the background screening.

SECTION B: CHILD CARE SERVICES FOR THE FOLLOWING CHILDREN WILL BE AFFECTED BY THIS ACTION

Child's Name:	Date of Birth:	SSN or RFA #:

SECTION C: This notice sent by:

Agency:_____ Address:_____ Phone #:_____

Worker's Name:_____ Worker's Signature:_____ Unit #:_____

Copies sent to:
☐ Welfare Transition Contracted Provider
☐ Economic Self-Sufficiency
☐ Protective Services/ Protective Investigations
☐ Child Care Provider
☐ Family Safety & Preservation
☐ Privatization Provider
☐ 4C Agency
☐ Other

SECTION D: Comments: (For agency use only: _____

_____

_____

_____

AWI 5235, SEPT 01 (Replaces CF-FSP 5235, Feb 99) Distribute copies to: RWB Provider, DCF PAS, Child Care Service Provider, and Participant

INSTRUCTIONS FOR THE NOTICE OF CHANGE IN CHILD CARE STATUS FORM

WHEN COMPLETING THE FORM, PLEASE PRINT CLEARLY

INTRODUCTION:
This form is intended to be the universal Notice of Change in Child Care Status form for child care services. It is designed to be used by authorized employees of the Department of Children and Families, Economic Self-Sufficiency and Family Safety and Preservation programs, Welfare Transition Providers and contract providers of these programs.

The person completing the form should indicate the name and address to whom the form is to be sent.

To: Enter client's name and address. **Date Mailed:** Enter date form is completed and mailed.
RFA #: Enter the request for assistance number.
SSN: Enter the social security number.

SECTION A: STATUS
Terminated: Check box if services are being terminated for a current client.
Denied: Check box if the client cannot be enrolled in services.
Redetermined: Check box if services for a current client need to be redetermined.
Note: Referring agencies will check either terminated or denied.
4C agencies will check terminated, denied or redetermined.
Date: Enter last day of child care services. (Allow no more than 10 calendar days before terminating.)
Check the box *to the left of the statement* that applies to the client's situation.
If using 1, 2 or 3, fill in the blanks with the appropriate information.

SECTION B: CHILDREN'S INFORMATION
Child's Name: Enter name of child affected by the action.
Date of Birth: Enter date of birth.
SSN or FLORIDA #: Enter child's social security number.

SECTION C: AGENCY/WORKER INFORMATION
Complete agency name and address in full.
Complete worker's information in full.
Copies sent to: Check appropriate boxes.

SECTION D: COMMENTS
Agency will enter any additional comments.

CareerSource

TANF Eligibility Form

Recipient Name: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

*SSN: _____ Date of Birth: _____

TANF FUNDS MUST BE EXPENDED TO MEET ONE OF THE FOUR PURPOSES OF TANF

1. Provide **assistance to needy families** so that children may be cared for in their own homes or the homes of relatives.
2. **End the dependence of needy parents** on government benefits by promoting job preparation, work and marriage.
3. Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing these pregnancies.
4. Encourage the formation and maintenance of two parent families.

Step 1: Citizenship/Qualified Non-citizenship Status

If the TANF program or service eligibility is a means tested benefit (income based), the family member(s) served **MUST** be:

____ An United States Citizen, or

____ A qualified non-citizen

If either line in Step1 is selected, go to Step 2. If neither line is checked, the person or family is NOT eligible for TANF funded services or programs if eligibility is based on income. The following toolbox has been provided to assist in the determination of citizenship/qualified non-citizenship status.

Citizenship and Qualified Non-Citizenship

Citizenship or qualified non-citizenship status is only required for "means tested benefits." This means eligibility for the benefit, program or supportive service is based on income. **If the TANF applicant does not meet a status criteria under Section A , B or C, (s)he is not eligible for TANF "means tested benefits."**

Section A: A United States Citizen is an individual who was born in the United States, born abroad to a United States Citizen meeting specific criteria, or the individual is naturalized. Is the individual/family member a United States Citizen? ☐ Yes ☐ No

Section B: The applicant is eligible if (s)he has one of the following INS statuses:

- **An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA);**
- **An alien who is granted asylum under Section 208 of the INA;**
- **A refugee who is admitted to the U.S. under Section 207 of the INA or a victim of human trafficking (these individuals must have their status verified by the Department of Health and Human Services);**
- **An alien who is paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least one year;**
- **An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241 (b)(3);**
- **An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980; or**
- **An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.**

Or, is a lawful permanent resident with a prior INS status identified above

Or, is a without a prior INS status listed above, and they were in the U.S. prior to August 26, 1996.

Does the applicant meet one of the above criteria in Section B? ☐ Yes ☐ No

Section C: The individual is eligible if (s)he meets one of the following two circumstances below. Does the applicant meet one of the two circumstances below? ☐ Yes ☐ No

- (S)he is a lawful permanent residents who are without prior INS status (above) and who entered on or after August 22, 1996;
- Or the (s)he is an alien who have been battered or subjected to extreme cruelty, or whose children/parents have been battered or subject to extreme cruelty.

If yes, the family is not eligible until five years after the date of entry. Please provide the date of entry ___/___/_____.

Step 2: Family Definitions

The family requesting services includes:

____ A **parent or relative** caring for one or more **children** (see definition of "child" below)
____ A **pregnant woman,** or
____ A **non-custodial parent** (see definition of "non-custodial parent" below)

Child: a dependent person under 18 (or under 19 who is still a full-time student in high school or at the equivalent level of vocation or technical training), who has never been married or whose marriage was annulled and whose eligibility is being determined.

Parent: includes a mother, father, adoptive mother and adoptive father.

Non-Custodial Parent: the parent is not in the household of the child (see definition for child above) whose eligibility is being considered. Both the non-custodial parent and the child must live in the State of Florida.

Blood Relative: including those of half-blood, within the relationship of siblings, first cousins, nephews, nieces, aunts, uncles and individuals of preceding generations as denoted by prefixes of grand, great, great-great, etc. This group includes relatives within the fifth degree of kinship to the dependent child; therefore, this includes first cousins once removed, but not the second cousins.

If any line in Step 2 is checked, continue to Step 3. If none is checked, the individual is only eligible for services accomplishing/supporting TANF purposes #3.

Step 3: Determination of Need

Depending on the purpose served, program, benefit or service, the family's income level may have to be determined. Although TANF purposes number #3 and #4 do not require a determination of "needy", the RWB or State may restrict benefits and services to individuals and families below a certain income.

A. What TANF purpose does the program, benefit or service accomplish?
Purpose 3: Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual

B. Does eligibility have income requirements? Note, if TANF purpose number #2 were written above, the answer is "yes." If the program is a State special project, and income requirements are a factor of eligibility, the answer is "yes." If the benefit or service is provided by the Regional Workforce Board through local operating procedures, and the eligibility requirements include income level, the answer is "yes." ☐ Yes ☐ No

C. If yes, does the family meet income eligibility requirements? ☐ Yes ☐ No

If income is strictly based on Florida's definition of "needy":

- Does the family receive Temporary Cash Assistance, relative caregiver program payments, food stamps or are the children in the family eligible for Medicaid? ☐ Yes ☐ No
- Is the family's total income less than 200% of the Federal Poverty Level based on household size? ☐ Yes ☐ No Number of household members: _____

If income is based on reporting instructions, local operating procedures or guidance, please review the appropriate materials for income eligibility determination.

Step 4: Self Attestation

The provider is to review the following statements with the program applicant/participant.

_____Income based or means tested benefits require "family eligibility". I understand that a family member may be designated as a non-applicant, and his/her information regarding citizenship or qualified non-citizenship status will not be required. I understand that my benefits or services will not be delayed if information regarding the non-applicant's citizen status is not provided.

PRIVACY ACT STATEMENT

_____*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

_____If I do not have a Social Security Number and do not know how to apply for one, I understand that I can request help from the One-Stop Career Center or other program provider identified below. The indicated person will refer me to the appropriate agency and may provide other help as needed and requested.

_____ I understand that my Social Security Number will be used to associate all records to my identification, including program participation and the receipt of services and benefits.

I _____ certify, to the best of my knowledge, the above information in this form is true, including income and citizenship/qualified non-citizenship information.

Name: _____ SSN: _____ Date: _____

Signature: _____ Phone Number: _____

Address: _____
Street Address City State Zip Code

_____ _____
RWB provider printed name RWB provider signature

_____ _____
Date Phone Number

RWB Comments: _____

_____

_____

TANF SUMMER PROGRAM PROJECT - 2021
Youth Services

Self-Attestation of Youth Participation in the Summer Program from

Date: _____ through Date: July 31, 2021

Attestation Statement

My signature below indicates that I have consistently participated in the _____ Summer Youth Program during the period as indicated above:

First Name	Last Name	Signature

I certify that the signatures on this document are a true representation of the youth participants, ages 13 to 19 who consistently participated in the teen pregnancy prevention program during this invoice period.

_____ _____

Printed Name (Person authorized to sign for host organization) Signature

Date

Chapter V, Exhibit "T"

INVOICE

Collaborate. Innovate. Lead.

CareerSource Escarosa
6913 N. 9th Avenue, Pensacola, FL 32504
Phone 850.607.8800 Fax 850.607.8851

Vendor Name: Enter company name.
Program Period: Agreed Upon Program Start Date to August 6, 2021

Invoice Period: 5/24/2021 **thru** 7/31/2021

QTY	DESCRIPTION	LINE TOTAL
	See Attached Signature Sheet of Participants Attestation of Engagement during Invoice Period – Youth Ages 13-19 Only	

Certification: I certify that the amount invoiced above is a true reflection of the number of participants in the program during the invoice period **who meet the required age criteria – 13 to 19 years of age**. I also certify that the supporting documentation which reflects each participants' signature as an attestation of full participation in the program during the invoice period is valid. I further certify that the invoiced amount reflects the agreed upon cost per participant as indicated in the initial application and that no student had to pay additional monies out of pocket to participate in this program.

Signature	Title	Date

Please submit your invoice to Kimberly Chastain via email:
kchastain@careersourceescarosa.com

NOTICE: CASH ASSISTANCE TIME LIMIT ENDING

Assessment and Review Appointment Letter

Date: *Last Four Digits of the SSN:

Participant Name: RFA:

Participant's Address:

To:

Based on the information received from the Department of Children and Families, you have reached your 48 months of Temporary Cash Assistance time limits.

We must meet with you concerning your hardship extension request to assess your employment progress and barriers to becoming employed. Together we will identify the steps necessary for you to become employed before your cash assistance ends. **Your appointment date and time is**:

DATE:

TIME:

ADDRESS: CAREERSOURCE ESCAROSA, 3670-B NORTH "L" STREET, PENSACOLA, FL 32505

During this meeting, you will be given an opportunity to request an extension of your time limits through the hardship extension process. If you cannot keep this appointment, you must call to reschedule. If you do not call, you may lose your cash assistance and/or food stamps.

If you have applied for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI), you may be eligible for an extension to your time limits while you are awaiting a final decision. The application must be current, including appeals. Please bring documentation regarding the status of your application. You can obtain a statement regarding the status of your application from your local Social Security Administration Office.

You are required to attend this appointment. If you have any questions about your Obligations and Opportunities as a participant in the Welfare Transition Program, please see the back of this letter. You may also call me at the below phone number. Please complete the Client Information Support Sheet for Hardship Extension Request attached to this letter.

Sincerely,

RWB Provider: Phone: (850)

*You have not been asked to provide your social security number on this form. For your information however, the Social Security Act (42 U.S.C. 1137) provides that your social security number may be used to administer the program, including determination of eligibility, attributing the receipt of services, correspondence and participation, as well as for reporting purposes.

AWI-WTP 0004, December 2006 (Replaces AWI-WTP 0004, 7/2003)

OPPORTUNITIES AND OBLIGATIONS

YOUR OPPORTUNITIES

You have the opportunity to:

* Receive help paying for support services (if approved) in order to find employment, education, or other assigned activity (ies), unless you are able to make these arrangements on your own. Support services may include, but are not limited to: child care, transportation, tools, clothing, uniforms, etc. (This help is based on your assigned activity and the availability of funding.)
* Have decisions about your case reviewed by a supervisor at the Regional Workforce Board.
* Request a hearing if you disagree with a decision about your temporary cash assistance.
* Be excused from or rescheduled for an activity if you have good cause. Good cause is determined by the Regional Workforce Board.
* Request Cash Assistance Severance Benefit.
* Request Relocation assistance.

YOUR OBLIGATIONS

You are required to:

* Participate in, document and complete assigned program activities.
* Respond to all contacts from the Regional Workforce Board or other agencies you are referred to.
* Inform Regional Workforce Board of changes in participation, employment, family circumstances including change of address, telephone number, child care needs, transportation problems, health problems, etc.
* Apply for and seek employment.
* Accept any reasonable offer of suitable employment.
* Remain employed. Must contact Regional Workforce Board prior to reducing your hours or quitting.
* Report good cause reasons for failure to participate immediately.

* Receive the following services, if eligible:
  - Mental Health Counseling - Domestic Violence Counseling/Services and/or - Substance Abuse Counseling/Services
* Receive transitional benefits, if eligible, after you are no longer receiving temporary cash assistance, based on funding availability, such as: - Child care - Transportation - Education and Training
* Receive Medicaid and food stamp benefits based on eligibility requirements.

CONSEQUENCES FOR FAILURE TO PARTICIPATE

CASH ASSISTANCE PENALTIES

* 1st Penalty: Cash assistance terminated for entire family for a minimum of 10 days or until the individual complies, whichever is later.
* 2nd Penalty: Cash assistance terminated for entire family for one month or until the individual who failed to comply does so, whichever is later.
* 3rd Penalty: Cash assistance terminated for entire family for three months or until the individual who failed to comply does so, whichever is later.

NOTE: Cash assistance may be continued on a level two or three penalty for children under age 16 through a protective payee.

FOOD STAMP PENALTIES

* 1st Penalty: Loss of food stamp assistance for one month or until compliance, whichever is longer.
* 2nd Penalty: Loss of food stamp assistance for three months or until compliance, whichever is longer.
* 3rd Penalty: Loss of food stamp assistance for six months or until compliance, whichever is longer.

NOTE: If the non-compliant individual is the head of household, food stamp assistance for the entire assistance group will be terminated unless that individual meets a food stamp exemption.

HARDSHIP EXTENSION STATEMENT OF UNDERSTANDING

___ Initial ___ Update

_____ _____
Participant's Name (Please print legibly) Last four digits of social security number

Hardship Extension Review Form (2082) has been received by the RWB: yes (Date: _____) no

- I have met with my Regional Workforce Board designee/Career Manager and talked about my current situation, how I can meet my job goal by the end of my cash assistance time limit, and to get information about the options through the Hardship Extension review procedure.
- I have been told that my cash assistance has been scheduled to end on _____.
- I have been told that if I request an extension of my months of cash assistance, my request will be reviewed and I will be advised by the RWB of the outcome of the decision about my request. To receive an additional extension, I must request the extension from my Public Assistance Specialist and/or the Regional Workforce Board.
- If I do not request an extension at this time, I reserve the right to request on at a later date.
- I have been told that any extension of months of cash assistance is counted as part of my lifetime limit of 48 months.
- I have been told that if I fail to meet any program requirement, not just work requirements, I may be sanctioned and my cash assistance and/or food stamp benefits may end.
- I have been told that if I am denied an extension of cash assistance, I have the right to request a fair hearing and my request for a Hardship Extension may be reviewed by the office of Family Safety since my cash assistance is ending.
- I understand that I always have the choice not to receive cash assistance and that it is my responsibility to inform my Public Assistance Specialist if I choose not to receive cash assistance.

The Hardship Extension policy and my options have been explained to me.

_____ _____/_____/_____
Participant's Signature Date

_____ (_____)_____ _____/_____/_____
Regional Workforce Board Designee (Please print legibly) Telephone Number Date

PRIVACY ACT STATEMENT
*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The Social Security Number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

AWI 2086, 1/2007 (Replaces AWI 2086 12/2001) **Distribute copies to: RWB and Participant**

SSI/SSDI TIME LIMIT EXTENSION REVIEW FORM

The following individual has a disability application for SSI/SSDI

_____ _____
Participant Name (please print) RWB Designee Print Name

_____ _____
RFA Case #/Category/Sequence DCF Unit Number

Section A: To be completed by the Public Assistance Specialist (PAS)

How many months has the participant received temporary cash assistance? _____ months

How many months does the participant have left of their lifetime limit? _____ months

Comments:

_____

_____

Note: If SSI/SSDI pending application verification is received, please attach and forward with this form to the Regional Workforce Board.

_____ _____ ___/___/___
(DCF PAS Print Name) Telephone Number Date

Address: _____

_____

_____

Section B: To be completed by the Regional Workforce Board

Time Limit Extension: _____ Approved - If approved, extension number: _____ _____ Denied

If appropriate, please check one of the following:

SSI/SSDI Approved: ____ Date Approved? ____/____/____ SSI/SSDI Denied: ____ Date Denied? ___/____/____

In Appeal Process: _____ Level of Appeal: _____ Application current and verified: yes no

Date Application Filed: _____

Comments:

_____

_____

_____

_____ _____ ____/____/___
Regional Workforce Board Designee Signature Telephone Number Date

Address: _____

AWI-WTP 2289, 12/2006 (Replaces AWI-WTP 2289, 12/2001) Distribute copies to: RWB Provider and DCF ESS

WT / SNAP INTERNAL MONITORING TOOL

Participant Name: **RFA:** **WT / SNAP**

1.	Was the participant case file available?	YES	NO	NA
2.	Was the Grievance/Complaint, EEO/Discrimination forms completed before 30 days after becoming MN?	YES	NO	NA
3.	Is there an O & O completed in OSST or paper copy in case file?	YES	NO	NA
4.	Was an initial assessment completed within 30 days of becoming MN?	YES	NO	NA
5.	Was an IRP/ARP completed, signed and dated at the initial appointment?	YES	NO	NA
6.	If the participant is a victim of DV, was a safety plan completed and filed and a referral to Favor House done and documented?	YES		NO
7.	Were the elements of the safety plan included in the IRP/ARP?	YES		NO
8.	If the participant is employed, was the employment verified? and documented in the case file and in OSST?	YES		NO
9.	Was the employment combined with another activity?	YES		NO
10.	If yes, did the total hours equal participation for WT or 120 hours or less for SNAP?	YES		NO
11.	Verify that the employment verification date was not earlier than the date stamp of the received documentation or phone call case note.	YES		NO
12.	If the verification was a phone call, did the case note have all the required info?	YES		NO
13.	Were employment retention services issued?	YES	NO	NA
14.	Is there documentation in the case file to support the amount of reimbursement for each FSR issued	YES	NO	NA
15.	Is documentation in the participant case file to support all JPR hours entered in OSST?	YES		NO

16. If the participant was assigned to ETOP or WE, were the hours assigned less than or equal to (not greater than) the hours of the benefit calculation? YES NO

17. Was a signed worksite agreement, work training outlines and worksite signature card in the participant case file? YES NO

18. If job search was the only activity, did it last for 4 weeks or less? YES NO

19. Was job search reduced to 39 hours or less after 4 consecutive weeks? YES NO NA

20. If the participant was assigned to continued JS after 4 weeks, did the job search last for less than 12 consecutive months? YES NO

21. If the participant failed to comply and complete requirements, was a sanction imposed immediately? YES NO

22. Was the participant notified of what he/she was required to do before initiating the pre-penalty? YES NO

23. Did the LWDB verbally attempt to contact the participant during the 10 day counseling period? YES NO NA

24. If it was a 2nd act within the past 30 calendar days, was the participant allowed 3 working days to provide good cause? YES NO NA

25. Was the Notice of Failure to Demonstrate Satisfactory Compliance (DEO- 2292) mailed? YES NO NA

26. Was the participant eligible to receive TS Services? (A full cycle pay stub received and filed) YES NO NA

Completed By; _____ Date:_____

Completed On; _____ Date:_____

Received by WT/SNAP Manager; _____

Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CHAPTER VI

Domestic Violence

VI. DOMESTIC VIOLENCE POLICY AND PROCEDURES

A. Welfare Transition Domestic Violence Procedures

Notification of Domestic Violence (DV) resources under Welfare Transition (WT) and SNAP and the screening of participants will start during WT/SNAP Work Registration automation process. All procedures in this chapter pertain to both male and female DV victims. Procedures are as follows:

1. During the Work Registration automation process, all WT/SNAP participants will be given information on DV resources and crisis line phone numbers. The local Favor House Domestic Violence Center pamphlet/brochure (Exhibit "A") will be made available to participants during their initial Career Advisor (CA) appointment and/or as situations arise.

2. Participants will be informed that disclosure of DV issues is voluntary. Confidentiality of self-disclosure and DV information will also be discussed.

3. Specifics regarding allowable exceptions or exemptions from the WT/SNAP work activity requirements due to DV issues will not be discussed in any group setting to ensure optimum safety of the participant.

4. After a participant has self-disclosed himself/herself as a DV victim in a current crisis situation, the Career Advisor will immediately meet with the participant.

5. All participants will be informed that he/she may disclose DV issues and ask for a referral to the local professional organization for further assessment and/or services at any time during participation in the program.

6. All WT/SNAP staff will have training to equip them in successfully handling emergency DV issues. This training will be provided by a trained DV educator.

B. Referral of WT/SNAP Program Participants

The following procedures will be followed after a participant has self-disclosed a DV issue to their Career Advisor.

1. During his/her Career Advisor appointment, the participant will be given the opportunity to call the FavorHouse Crisis Line phone number immediately.

   The Crisis Line Numbers:
   Escambia County = (850) 434-6600
   Santa Rosa County = (850) 994-3560

   The participant is provided with FavorHouse pamphlets whether or not the phone call is made.

   The participant is provided with CareerSource Escarosa Safety Plan for Domestic Violence (Exhibit "B")

2. The Career Advisor will establish an alternative responsibility plan as part of the participant's Individual Responsibility Plan (IRP) which will also include a safety plan. The outline of that alternative plan is in the Favor House Domestic Violence Center Safety Plan (Exhibit "C"). The DV participant must never be encouraged to do any activity that he/she believes will place them in danger.

   Under no circumstances should WT/SNAP staff encourage the participant to apply for an injunction to leave his/her home as this is a time when the DV victim is most at risk for harm and only the

victim can make these decisions. All DV victims are required to assemble documentation to verify domestic violence.

Acceptable activities that may be incorporated as elements of an alternative plan may include, but are not limited to the following:

- Obtain emergency shelter at a safe house
- Participate in DV individual or group counseling
- Participate in peer support groups
- Apply for an injunction for protection or other legal assistance
- Participate in case management activities at a victim services agency
- Attempt temporary or permanent relocation
- Participate in prosecution of the perpetrator
- Participate in life skills training
- Participate in pastoral counseling
- Participate in substance abuse treatment related to coping with domestic violence
- Participate in various levels of safety planning
- Participate in stress management activities
- Participate in parenting classes
- Receive medical treatment related to domestic violence
- Participate in mental health counseling
- Work with a domestic violence advocate

3. All DV participants who are waived from work activities will have an Alternative Responsibility Plan completed and signed by both the Career Advisor and the participant.

4. A Release of Information (Exhibit "D") is signed by the participant to allow the Career Advisor to communicate on a specific subject with another agency (i.e., FavorHouse, etc.).

5. If the participant is assigned to any counseling, he/she will submit a Verification of Counseling form (Exhibit "E") in addition to a Weekly Counseling Session Attendance sheet (Exhibit "F") to verify activity completion.

6. The Career Advisor will then put the participant in the DV tracking code system via the "Alternative Plan" screen in the One Stop System Tracking (OSST) system or a paper form indicating that this participant will be receiving DV services.

The two determining factors in deferring a WT/SNAP domestic violence participant from countable work requirements are the ongoing safety of the participant and the goal of self-sufficiency.

7. Transportation and childcare assistance will be authorized, if necessary, in order for the participant to complete his/her alternative plan activities.

8. Relocation Assistance for any DV participant who believes his/her safety is at risk will be discussed with the DV participant by the Career Advisor. If applicable, a relocation budget worksheet will be provided to the participant along with a timeframe to return the information.

9. A follow-up appointment is scheduled based upon the participant's needs. Each DV participant must be seen as needed and always to put their safety first.

10. At any time, if the participant identifies that he/she is not currently in a crisis or emergency situation, the Career Advisor will determine if the participant is able to participate in regular WT or SNAP work activities.

If the participant does not need an alternative plan, he/she will still be tracked in DV but placed in regular WT or SNAP work activities

with the understanding that DV issues could resurface at any time. This will be taken into consideration when reviewing incidents of non-participation.

11. If there are any unusual questions or issues concerning confidentiality or the safety of a DV participant in the WT/SNAP program that cannot be resolved by the Career Advisor, the WT/SNAP Program Manager will intervene and if necessary, the situation will be brought to the attention of the CareerSource Chief Operating Officer or Chief Executive Officer.

C. Hardship Extension of Time Limits

Victims of domestic violence may be granted a hardship extension of established time limits if the effects of DV delay, interrupt, or adversely affect the individual's participation in the WT or SNAP program and his/her ability to achieve self-sufficiency (See Chapter V of this manual for guidance).

CHAPTER VI
DOMESTIC VIOLENCE PROGRAM

EXHIBITS

- Exhibit “A” – Favor House Domestic Violence Center pamphlet/brochure
- Exhibit “B” - CareerSource Escarosa Safety Plan for Domestic Violence
- Exhibit “C” – Favor House Domestic Violence Center Safety Plan
- Exhibit “D” – Release of Information
- Exhibit “E” – Verification of Counseling
- Exhibit “F” – Weekly Counseling Attendance

SPEAKERS

To learn more about domestic violence, contact FavorHouse and request a speaker.

CALL:

Escambia County (850) 434-1177
Santa Rosa County (850) 626-5600

YOU CAN HELP STOP DOMESTIC VIOLENCE IN OUR COMMUNITY.

☐ Enclosed is my tax deductible donation of $_____

_____ _____ _____ _____
Name

_____ _____ _____ _____
Address

_____ _____ _____ _____
City State Zip

( ) _____ ( ) _____
Home phone Work phone

A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE, WITHIN THE STATE. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL, OR RECOMMENDATION BY THE STATE. 1-800-435 7352

United Way

FavorHouse is a non-profit corporation which is partially funded by the Florida Coalition Against Domestic Violence. The remaining funding is received through community donations. FavorHouse provides services without regard to race, sex, color, national origin, religion, age or disability.

COUNSELING CENTERS:

2001 West Blount St.
Pensacola, Florida 32501
Phone: (850) 434-1177
Fax: (850) 434-9987

6480 Highway 90, Suite B
Milton, Florida 32570
Phone: (850) 626-5600
Fax: (850) 626-4603

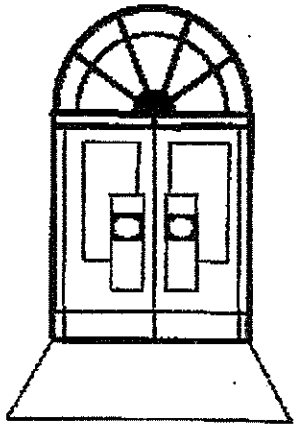
CRISIS LINES:

Escambia County (850) 434-6600
Santa Rosa County (850) 994-3560

SHELTERS LOCATED IN ESCAMBIA COUNTY AND SANTA ROSA COUNTY

If someone you know is suffering from domestic violence:

We can help.



FavorHouse of Northwest Florida, Inc. Mission Statement: With a commitment to excellence in our service to victims of domestic violence and sexual assault, we actively work toward every intimate relationship to be violence free.

A Domestic Violence Center serving Escambia and Santa Rosa Counties

(Rev. 2/09)

In the time it takes you to read this brochure, someone will feel the pain of domestic violence. Physical and psychological abuse within the home has a profound effect on every member of the family; and if it is to be stopped, the issue must be dealt with openly and realistically.

Consider these facts:

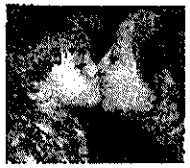
- According to the Attorney General of the United States, domestic violence is the leading cause of injury to women ages 15-44, more common than automobile accidents, muggings and rape combined.
- 17 to 26% of pregnant women are battered.
- The cost of intimate partner violence exceeds $5.8 billion each year, $4.1 billion of which is for direct medical and mental health services.
- Domestic violence is one of the most chronically underreported crimes.

Domestic violence affects all races, all socio-economic classes and all faiths.

The cycle of violence is broken by:

- Intervention
- Education
- Providing services for victims of domestic violence and sexual assault
- Holding the offender accountable

THE CHILDREN



- Research shows that domestic violence is present in over 40% of child fatalities.
- 30 to 60% of perpetrators of intimate partner violence also abuse children in the household.
- Witnessing violence between one's parents or caretakers is the strongest risk factor of transmitting violent behavior from one generation to the next.
- In order to protect the children, we must FIRST protect their mothers.

HISTORY OF FAVORHOUSE

Since 1979, FavorHouse has provided safe shelter to thousands of domestic violence victims and their children. Thousands more have received assistance through the FavorHouse crisis lines, the outreach counseling centers and advocacy services.

CRISIS INTERVENTION

FavorHouse shelters and crisis lines are staffed 24 hours a day, year round. Victims, their families and those who are assisting them may call for help at any time. Victims who do not want a long-distance call to appear on their phone bills, may call FavorHouse collect.

A SAFE PLACE TO STAY

- Self referrals, call (850) 434-6600 or (850) 994-3560 where you can speak to a counselor 24 hours a day, seven days a week, day or night.
- The location of the shelter is confidential.

OTHER SERVICES

In addition to refuge and crisis services FavorHouse provides: educational programs for victims, support groups for victims, victim advocacy, non-residential counseling, information and referral, community education, professional training and a certified batterer's intervention program.

ELIGIBILITY

To be eligible for safe shelter, a person must be:

- A victim of domestic violence by an intimate partner
- A victim of sexual assault
- In need of a safe place to stay

When coming to the residence, we recommend that you bring the following items, if possible:

- Driver's license or other identification
- Health insurance cards
- Money, checkbook or credit cards
- Children's birth certificates and health records
- Several changes of clothes but not more than one suitcase per person
- Citizenship papers if applicable

FAVORHOUSE GOALS

- To establish violence free homes
- To provide safety for victims and children
- To break the cycle of violence
- To hold offenders accountable

(Rev. 2/09)

CareerSource Escarosa
WT / SNAP

SAFETY PLAN FOR DOMESTICE VIOLENCE

The CareerSource Escarosa Safety Plan for Domestic Violence will include the following action steps:

1. Meeting with the Client by the Career Advisor to conclude that there are possible Domestic Violence issues. (The Client is urged during Work Registration to go directly to Favor House if needed)

2. Submit a referral sheet for the client to give to the Professional Domestic Violence agency called Favor House.

3. The Client's Career Advisor will call Favor House to let them know of the referral and the name of the client.

4. The WT/SNAP Career Advisor will provide the client with the Favor House Safety plan and request that the client fill out prior to their appointment with Favor House.

5. The WT/SNAP Career Advisor will provide the client the Favor House Hot Line Number.

6. The Career Advisor will have the client sign the DV statement below and retain that statement in the client's WT /SNAP case file.

DV Statement:

I _____ have been counseled concerning Domestic Violence and the WT Program which includes a referral to the local Domestic Violence Professional at Favor House in Pensacola Florida. I have been provided a Favor House Safety Plan along with their contact phone number by my Career Advisor / WT/SNAP Staff at CareerSource Escarosa. I have been offered help to call the Domestic Violence hotline at 1-850-434-6600 to speak with a counselor to help make a customized plan for me.

Client Signature and Date

Career Advisor / WT / SNAP Staff Signature and Date

1. If you are being physically, sexually or emotionally attacked — You are not alone

Domestic violence is a crime and it is against the law. If you have been hit, pushed, grabbed, punched, held, or attacked in any other unwanted way by your life partner, spouse, boyfriend or girlfriend, someone you have a child with, someone you have lived with, or a family member, you are a victim of domestic violence. If you have been forced to do something sexual that you didn't want to do or if you have been kept from food or medicine or a doctor's care, you are a victim of domestic violence. It is not your fault. The abuser is responsible. There is someone who will listen and support you and your decisions. There are steps you can take to help end the abuse.

Some actions you may want to consider:

Call the police in an emergency or file a report about the violence.

Call the domestic violence hotline to talk, get information or ideas, find a shelter, or make a safety or escape plan.

Have the abuser ordered by the court to stay away from you by getting an injunction for Protection.

See a doctor for injuries (and consider having him/her write down what caused the injuries).

Talk to a friend, family member, neighbor or someone else for support and ask for help.

2. How to Use This Pamphlet

- Keep it in a safe place. (At work, a friend's, etc.)
- Read it carefully, then call the domestic violence hotline (1-800-434-6800) and ask a counselor to help you make a plan. Everyone is different, and your plan should cover your personal situation.
- Put your important phone numbers together so that they will be handy if you leave.
- Check-off items which will apply to your situation. See what will help you the most and concentrate on those items.
- Up-date your safety plan often. Review it with a supporter or hotline counselor.
- Share your plan with those who will absolutely support you. Do NOT share it with anyone who may tell or "let it slip" to the abuser or his supporters.

3. Tips to Increase Safety While Still at Home

Will Do	Done
Practice an escape plan for emergencies.	
Go over it with a counselor or advocate.	
Teach children emergency and escape action and phone use.	
Keep payphone change in a safe place for kids/children.	
See if family car/truck can be taken without being seen or stopped.	
Use portable or cellular phones, if possible.	
Use noise-makers (whistle, personal alarm etc.) to get help.	
Ask neighbors to listen, watch and call police about suspicious people or activities.	
Let someone know if you feel violence is about to happen.	
When violence does seem close, avoid the kitchen, bathroom, and rooms without doors to the outside.	
Begin action on safety plan at any sign of [illegible]	

4. "Escape Bag"

Prepare a bag, box, or suitcase filled with things you will need if you leave. Keep it in a safe place away from home, if possible. The escape bag is a secret from the abuser or anyone who could tell him/her you are leaving. Place "originals" in the bag except for the items you must have with you or things you can't take without the abuser noticing.

Will Need	Done
Identification (driver's license, passports, green card, work permits).	
Birth certificates for self and children.	
Social Security Cards for self and children.	
Extra car, house, storage, or other keys.	
Checkbook, ATM card.	
Credit cards, bank books, etc.	
Address book/phone numbers.	
Food Stamps, Medicaid Cards, etc.	
Car registration.	
Car, health, and life insurance papers.	
School and medical records.	
Divorce, custody, or injunction papers.	
Proof of income for partner (check stub).	
Pre-paid long distance card.	
Home calling card (calls can be traced).	
Copies of bills you owe with your partner.	
Change of clothes.	
Medicine and prescriptions (extra).	
Personal hygiene products (tampons, toothbrushes, deodorant, etc.).	
Diapers, formula, toys, blankets.	
Pictures, jewelry, keepsakes.	
Picture of abuser (I.D. to serve court papers).	

5. More Tips for Safety

(Use tips from #4 in addition to the following)

Will Consider	Have Done
Remember, the danger may get worse during an escape or after leaving a violent relationship.	
Have a safety plan for as long as there is communication with/from the abuser and longer. Review it with a counselor often.	
If you move, put the rent, phone, and utilities in someone else's name.	
Make sure all locks (doors and windows) and lights (inside and out) work properly.	
Install door, window and smoke alarms, metal doors, etc.	
Get an unlisted phone number. (Change old number, if necessary)	
Get an injunction for Protection. (Call 1-800-434-6800 for information.)	
Keep copies of injunction orders at home, work, and in purse.	
Have another person to deliver and pick up children if a judge orders visitation.	
Use a post office box instead of a street address. Check it during busy hours.	
Report suspicious things to police, file violations of the injunction, as necessary	
Keep a copy of divorce, custody orders, etc. at school.	
Make special arrangements to pick-up children from school.	
Ask school to call about any unusual contact by abuser.	
Make some arrangements with childcare/babysitters as above.	
Have mail sent to the domestic violence center to be forwarded to you or to another safe place. Do not file change of address card with post office (it is not private).	

6. Preparing at Work

It is important for survivors of domestic violence to be alert and prepared for possible contacts by the abuser during a work day. A safety plan for work may help you if the abuser calls or shows up.

Will Do	Done
Tell co-workers/boss about situation. Ask the person(s) to call police in an emergency.	
Have a back-up person if the first one is not at work or nearby.	
Ask someone to screen your calls.	
Ask someone to watch-out for you.	
Plan your entry and exit each day.	
Keep a copy of your injunction at work.	
Let others know about the injunction.	
Request office or desk to be placed in a safe location.	
Plan an escape route.	
Have a signal for help (w/visibility).	
Find a safe room with a phone to use in an emergency.	

If you are in a situation that requires you to escape, it is important to keep this pamphlet and other critical information in a private, safe place.

7. If you live in rural area

Because of small population, family ties, and social closeness, it can be hard for survivors in rural areas to get help. Many people who live in rural areas cannot leave their home without being noticed or stopped (even for social communication). When shelters and services are located in larger cities, survivors must travel there to receive help. Staying or returning to a rural area can be safe for many, but domestic violence counselors (Phone 1-850-434-6600) can help you decide and plan.

We advise	Arranged when needed
Go to a shelter in another town/county (Call 1-850-434-6600 for the nearest shelter.)	
See if it is safe to stay with friends/family, local or out of town.	
Make a special escape plan if I take police too long to get here.	
Make a special escape plan because of travel/time problems.	
See if family contact can be taken without being seen or stopped.	
Get a ride from a trusted friend or family member. Get transportation from the county or health department.	
Keep an escape bag at church, with a friend, at health department, etc.	
See if leaving and getting away safely can be done without someone alerting the abuser.	

8. Preparing for feelings

Leaving a relationship, even an abusive one, is very difficult. It is important to know that you may feel sad, lonely, or guilty. Having friends and others to talk to can make a difference.

Please consider:

- Calling 1-850-434-6600 when you feel lonely or upset.
- Joining a church, synagogue, temple or mosque, if appropriate.
- Taking classes, going to workshops or seminars.
- Getting involved with children's activities.
- Volunteering — call the United Way or your local domestic violence center.

Places to Call for Support
(Enter phone numbers for your area.)

Domestic violence center hotline: 1-850-434-6600
local: _____
Sexual Violence Counselor or Center: _____
Alteen or A.A.: _____
Church Groups: _____
Social Clubs: _____
School Groups: _____

People to Call for Support
(Enter phone number for anyone you can call.)

Family member(s): _____
Friend(s): _____
Co-worker(s): _____
Neighbor(s): _____
Church: _____
Others: _____

Other Important Numbers
(Enter phone number you may need.)

Doctor's Office: _____
County Transportation: _____
Medical Transportation: _____
Taxi: _____
Greyhound/Railways Bus: _____
Child's School(s): _____
Lawyer: _____
Public Assistance: _____
Food Stamps: _____

For Assistance

Favor House	1-800-434-6600
Florida Domestic Violence Toll Free Hotline	1-800-500-1119
Child Support Assistance	1-800-622-KIDS
Florida HIV/AIDS Hotline	1-800-FLA-AIDS
Spanish	1-800-545-SIDA
State Abuse Registry (formerly HRS)	1-800-962-2873

(Call here to report child abuse, elderly abuse, or abuse to the disabled.)

Important Numbers for Personal Use
(Enter phone numbers for your area.)

Police or Sheriff: 911 (if available)
(other local numbers): _____
Police Victim Advocate: _____
Assisting Officer or Deputy: _____
State Attorney Advocate: _____
Injunction Counselor: _____
Domestic Violence Counselor: _____

To Assist in Dealing with the Abuser
(Enter phone number for anyone you can call.)

Address or someone who can reach him/her:
_____
_____
Phone #: _____
Social Security Number: _____
Employer: _____
Phone #: _____
Lawyer: _____
Phone #: _____
Car Make: _____ Model: _____
Year: _____ Color: _____ Tag Number: _____

If you know someone being abused —
Do not look the other way

- Let them know you are concerned about them.
- Offer to listen.
- Respect their choices, but encourage them to talk with professionals about safety issues.
- Offer as much help as you can, but do not take risks with your own safety. Examples of help: childcare, transportation, a place to stay, a job, lending money.
- Give them a copy of this pamphlet.

Special Telephone Services
Some telephone companies offer services that may help domestic violence survivors. These services may also be used by abusers to harass, stalk or threaten or find survivors. Most require phone company charges. Some of the services include:

Operator Assistance: Operators can dial police and other emergency numbers if you cannot do it or do not know the number. If you do not have some of the services listed below, operators in your area can advise you of other services if they exist.

Voice Mail: Allows you to have a phone number and get messages without answering the phone. No one has to know it's just voice mail.

Caller I.D.: Shows and records the numbers that call your phone. You have to buy a special electronic box to plug into the phone.

Call Block: Keeps caller I.D. from recognizing your number.

Call tracing: Dialing *57 on a tone operated phone or 1157 on a rotary phone verifies to the police the last call into your number.

Last number re-dial: Dialing *69 on a tone operated phone or 1169 on a rotary phone dials back the last call into your phone.

Collect calls and calls billed to another number: Use caution when making these calls. They can be traced. If calling the batterer, make these calls from payphones out of your neighborhood or town. Consider buying a "pre-paid" calling card.

Favor House
2001 West Blount Street
Pensacola, FL 32501
6852 Caroline Street, Suite B
Milton, FL 32570

DOMESTIC VIOLENCE SAFETY PLAN

Leaving an abusive relationship can be dangerous. This pamphlet has a sample safety plan for getting out of a relationship and suggests some things which could help you to stay safe. Each domestic violence case is different. Abusers are not predictable. Safety plans should be made with help of a domestic violence counselor or advocate.

A counselor may be reached
24 hours a day by calling

Favor House
Domestic Violence Center
Crisis Lines
Escambia County: 850-434-6600
Santa Rosa County: 850-994-3560

SAFETY/EMERGENCY PLAN

Having a plan will best ensure that one can leave safely with children, valued possessions, family pets and on one's own terms. Practicing each step with everyone involved reduces risk; safety planning removes many surprises and should continue during a victim's stay in a shelter and should include planning for many different situations which may arise. It should also include planning for a victim's intended return home.

☐Yes ☐No **Know how to get away (best route to take, method of transport).**
☐Yes ☐No **Know where to go for shelter, services, and help.**
☐Yes ☐No **Know how to stay in contact with helpers.**
☐Yes ☐No **Know what to do for children's safety.**
☐Yes ☐No **Know how to stay safe while at work and at play.**
☐Yes ☐No **Know what to do with family pets.**
☐Yes ☐No **Know what must be taken if leaving quickly.**
☐Yes ☐No **Know what each member of the family must do to leave safely.**
☐Yes ☐No **If in a domestic violence center, know how to travel to/from it safely.**
☐Yes ☐No **Know what to do if confronted by abuser (e.g., in court, at home).**
☐Yes ☐No **Know it may be necessary to change services (bank, doctors, etc.).**
☐Yes ☐No **Know that help is available: advocates, cell phones, campus/job security officers, injunctions for protection, etc.**
☐Yes ☐No **Know that it is safe to travel with a third person.**
☐Yes ☐No **Know it may not be best to take children to any meeting w/abuser.**
☐Yes ☐No **Know that the abuser's main objective is to get partner to return**

PLEASE INITIAL ONE BELOW

_____ **THE STAFF HAS OFFERED SAFETY/EMERGENCY PLANNING TO MY FAMILY AND ME.**

_____ **THE STAFF HAS OFFERED SAFETY/EMERGENCY PLANNING TO MY FAMILY AND ME BUT I DO NOT WISH TO PARTICIPATE AT THIS TIME.**

_____ **I AM AWARE THAT I CAN ASK FOR SAFETY PLANNING ASSISTANCE AT ANY TIME AND AN ADVOCATE WILL ASSIST ME.**

_____ **I WOULD LIKE MORE INFORMATION ABOUT:** _____

DATE: _____ **SIGNATURE:** _____
(CLIENT/RESIDENT)

NOTES: _____

Release and Authorization

I, _____do agree to the following concerning my support counseling at FavorHouse:

1. **Release of Liability**: I do hereby release FavorHouse and all of its personnel from any liability resulting from my support counseling.
_____(Client's Initials)

2. **Authorization for Release of Information from FavorHouse:** I hereby authorize FavorHouse to release any information concerning myself or my dependents to the appropriate local, state or federal agency or organization.
_____(Client's Initials)

3. **Authorization for Release of Information to FavorHouse:** I hereby authorize any local, state or federal agency or any other organization or person to release to FavorHouse any information concerning myself or my dependents.
_____(Client's Initials)

4. **Authorization for FavorHouse to Determine Eligibility for Economic Services:** I hereby authorize FavorHouse to contact Economic Services to determine If you meet financial guidelines for their program.
_____(Client's Initials)

5. **Authorization for FavorHouse to Exchange Information with Northwest Florida Legal Services (NWFLS):** I hereby authorize FavorHouse to call NWFLS and to exchange information about my case with NWFLS.
_____(Client's Initials)

6. **Authorization for FavorHouse to Exchange Information with the Department of Children and Families Protective Services:** I hereby authorize FavorHouse *to call, and* to exchange information about *my* case with the Department of Children and Families Protective Services.
_____(Client's Initials)

I hereby acknowledge that this release and authorizations are freely and voluntarily made by me this_____day of _____, 20___

Witness_____ Participant_____ Chapter VI, Exhibit "D"

CareerSource ESCAROSA

Verification of Counseling

NAME: _____ RFA# _____

DATE: _____

In order to continue your domestic violence deferral, you must have the following information completed and returned to our office.

Counseling Facility: _____

Counseling Program Title: _____

Length of Counseling Program: _____

Beginning Date: _____

Anticipated Completion Date: _____

Counselor Official Signature: _____

Title: _____

Phone: _____

Date Completed: _____

_____

Participant Signature

CareerSource ESCAROSA

Weekly Counseling Session Attendance

Employee Name: _____ **RFA#:** _____

Counseling Facility: _____ **Career Advisor:** _____

Week Starting: _____

Must be submitted to CareerSource Escarosa by 1:00 pm Monday
Fax: (850) 607-8851

Day of Week	Date	Time In	Time Out	Total Time	Counselor's Signature
Sun					
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					

Weekly Total: _____

_____

Participant's Signature **Date**

Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CHAPTER VII

Post-Employment Services and Transitional Benefits

VII. POST-EMPLOYMENT SERVICES AND TRANSITIONAL BENEFITS

A. Eligibility

Transitional benefits are provided to assist participants with the transition from dependence on public assistance to an employed, self-sufficient lifestyle. Based upon budget constraints and participating partnership policies, transitional benefits may be available to Welfare Transition (WT) Program participants who:

- Leave Temporary Cash Assistance (TCA) with Employment
- Have been redirected from applying for TCA through Up/Front Diversion. (Depending upon Early Learning Coalition (ELC) policy and funding availability).
- Individuals who have received Relocation Assistance (depending upon the availability of funds through the state and/or local workforce board into which a participant relocates).

Eligibility Requirements:

a. Earned income must be sufficient to cancel cash assistance.

b. The participant has chosen to take cash severance and can show that he/she requires transitional benefits to continue employment at least 20 hours weekly. These participants are only eligible for Transitional Childcare (TCC). ELC will determine eligibility and approve or disapprove.

c. Participants that have recently relocated to the area may be eligible for TCC to maintain employment if they are employed for at least 20 hours a week and were relocated through an approved WT or CareerSource Program from another region. ELC will determine eligibility and approve or disapprove.

d. The participant is no longer eligible for TCC due to time limits expiring and is employed at least 20 hours weekly. These participants may be eligible for TCC only for their employment. ELC determines eligibility.

B. Transitional Services and Transportation Benefits

1. Types of Transitional Benefits Available

a. Cash Severance

<u>Eligibility</u>

If a participant is employed and expects to remain employed for at least six (6) months but is still receiving a recurring TANF benefit of $99.00 or less monthly, he/she may elect to receive a one time cash severance payment. The participant must provide employment and earnings information with the request.

Cash Severance is a one time lump sum payment of $1,000.00 in which the participant agrees not to apply for TANF for at least six (6) months, unless an emergency is demonstrated to WT.

The cash severance will be initiated by the WT Career Advisor (CA) by completing a Cash Assistance Severance Benefit Agreement (Exhibit "A"). After the agreement is completed, the CA will submit it to the WT Program Manager with the Individual Cash History attached.

The participant must be eligible for ongoing cash assistance for the month in which the payment is issued. The application may not be backdated to a month in which the client was eligible. If the participant is no longer eligible even if they have met all other eligibility criteria, the cash severance payment will not be authorized.

A participant that chooses the Cash Assistance Severance benefit must be provided with information regarding all available transitional benefits. The participant may still receive transitional benefits and support services in addition to his/her cash severance, in accordance with policy and fund availability.

The participant must also be counseled that the severance payment only counts against their lifetime limits in the month the payment is received.

b. Transitional Childcare

Transitional Childcare (TCC) may be available for up to two (2) years depending upon funding availability and ELC policy. TCC may be available to WT participants who exit the WT program due to employment, to applicants of TCA who are diverted from ongoing cash assistance through UpFront Diversion, and to Relocation Assistance recipients.

Clients will be referred to ELC to determine eligibility for Transitional Childcare for up to two years (depending on ELC policy and funding availability) according to the following ELC guidelines:

- The individual remains employed at least 20 hours per week.
- If the individual loses employment, he/she secures subsequent employment within 30 days.
- The family's income remains below 200% of the poverty level.
- A child included in the grant calculation under age 19 remains in the home. This includes children who would be

included in the benefit, except that they are receiving SSI as determined by the ELC.

- The family has a need for TCC.

- TCC depends upon local operating procedures, resource allocation, and funding availability. The local ELC will approve or disapprove all referrals.

  Individuals receiving TCC may lose employment for various reasons. If the individual loses employment, a Loss of Income form must be submitted so he/she may receive TCC for up to 90 calendar days to complete job search activities, as determined by the ELC. The 90 calendar days begins on the date of the job loss.

c. Transitional Transportation

The Transitional Transportation Benefits policy provides that WT participants who are eligible for Transitional Benefits receive 30 days of Transitional Transportation, if funding permits.

Participants are required to submit a full cycle pay stub or another documented form of payment during the 30 days of Transitional Transportation in order to receive assistance.

d. Transitional Support Services

Transitional Support Services are available for 30 days, depending upon the availability of funds. A participant must initiate any and all requests for Transitional Support Services and submit necessary supporting documentation within the allowable 30 days of Transitional Support.

Transitional Support Services may include, but are not limited to:

- Clothing/Uniform Assistance
- Tools
- Testing /Assessments
- Licenses / ID Fees
- Emergency Rental/ Utilities Assistance
- As determined and approved by the WTP Manager

Note: (For specifics on each support service see Chapter IX Support Services)

CHAPTER VII
POST-EMPLOYMENT SERVICES AND TRANSITIONAL BENEFITS

EXHIBITS

- Exhibit “A” – Cash Assistance Severance Benefit Agreement

CASH ASSISTANCE SEVERANCE BENEFIT AGREEMENT

Name (please print) | Social Security Number

Case#/Category/Sequence | AG size/Months | Remaining On Time Limit/Extension

Section A: To be completed by the participant

I understand that I may be eligible to receive a one-time, lump-sum cash assistance severance benefit payment of $1,000 instead of ongoing Temporary Cash Assistance (TCA). I certify that I have received TCA for at least six consecutive months in Florida since 10/1/96. If I receive the Cash Assistance Severance Benefit payment, I may not apply for Temporary Cash Assistance again for six months, unless an emergency is demonstrated to the Regional Workforce Board. I further understand that if I receive a Cash Assistance Severance Benefit and reapply for TCA within six months due to an emergency, I will have to repay the amount received.

I may be eligible to receive transitional services, including childcare, for up to two (2) years after leaving the program. Transitional services and benefits may include Medicaid, transportation, childcare, and education and training. Receipt of Medicaid and food stamp benefits are subject to the eligibility requirements of those programs. I certify that I am employed and expect to be for at least six months and agree to provide verification of employment and earnings.

Participant's Signature | Date

Section B: To be completed by the Regional Workforce Board provider

☐ The participant is employed and receiving earnings and has provided verification.

☐ The participant expects to be employed for at least six months.

☐ The participant is potentially eligible to receive a $1,000 Cash Assistance Severance Benefit. (Use Diversion Services Eligibility Screening Tool to determine potential eligibility)

Regional Workforce Board Provider (print name) | Telephone Number

Regional Workforce Board Provider Signature | Date

Section C: To be completed and verified by the Department of Children and Families

☐ The participant received Temporary Cash Assistance for at least six consecutive months in the State of Florida, since 10/1/96.

☐ The participant is currently receiving and eligible for on-going Temporary Cash Assistance.

☐ The participant requested the Cash Assistance Severance Benefit prior to the last month of their established time limit or extension of limit for receipt of Temporary Cash Assistance.

VERIFIED BY:

DCF ESS- Name (please print) | Date | Telephone Number

If ineligible, DCF should contact RWB staff, who initiated the request, to advise which criteria the participant failed to meet

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

AWI WTP-2286, 12/2006 (Replaces AWI - WTP 1/2004) Distribute copies to: DCF ESS, RWB Provider, and Participant

Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CHAPTER VIII

Relocation Assistance

VIII. RELOCATION ASSISTANCE

A. Program Description

In accordance with state and local policy, CareerSource Escarosa has developed local policy and procedures for Welfare Transition (WT) Relocation Assistance (RA) service for Escambia and Santa Rosa counties. The purpose of this service is to assist WT clients who have obtained employment in another location that requires them to move closer to their place of employment. It also aids victims of domestic violence who would benefit from reduced probability of further incidents through relocation and obtain employment in the area requested. RA is designed for applicants who are eligible for temporary cash assistance (TCA) and meet all eligibility criteria for upfront diversion. Eligibility for RA is based on funding availability and determined on a case-by-case basis.

B. State Policy Requirements

1. Relocation Assistance provides qualified applicants with a cash sum of their approved relocation budget amount in one (1) lump sum. For individuals receiving TCA, the payment is applied to the EBT card and only counts toward TCA lifetime limits in the month in which it's received.

2. The applicant must be either pending for TCA as determined by the Department of Children and Families (DCF) or a WT participant already receiving cash assistance.

3. The applicant must either reside in an area with limited employment or show reasonable employment opportunity in the new location as documented through an employment offer or job searches.

4. The applicant must sign the agreement located in the Relocation Assistance Program Checklist (Exhibit "A"), stating that he/she will not apply for cash assistance for six (6) months unless an emergency condition exists in accordance with the following:

a. Hospitalization or illness documented by a physician licensed under Florida Statutes

b. Loss of housing

c. Natural disaster responsible for the destruction of an applicant's major property

d. Domestic violence

e. Other situations of a similar nature affecting employment, such as mass layoffs or destruction of a work site

CareerSource Escarosa determines whether or not the family meets an acceptable emergency reason.

5. Either the entire RA amount or a portion of this amount must be repaid if the assistance group reapplies within six months due to an emergency, except in cases involving domestic violence. If a family fails to relocate, the entire amount of the relocation payment must be repaid. This is determined by DCF.

If fraud is suspected or if the entire family fails to relocate within 90 days of receiving RA, the entire amount of the relocation payment must be repaid. WT will notify DCF by submitting a benefit recovery referral via the DCF FLORIDA ACCESS system. If fraud is later established by DCF, the relocation assistance payment will be recouped according to the amount of the established claim. DCF will be responsible for processing and collecting all repayments.

6. There is no maximum distance restriction within the United States however the individual is required to move a minimum of 50 miles from their current residence.

7. Acceptable Reasons for Relocation Assistance are:

    a. The applicant must either reside in an area with limited employment or show reasonable employment opportunity in the new location as documented through an employment offer or job searches.

    b. The applicant lives in a rural area with little work available, as documented by unemployment rates or the Career Advisor's knowledge that suitable employment is unavailable.

    c. There is a lack of public transportation, exorbitant costs of transportation or other formidable transportation barriers.

    d. The applicant is isolated from extended family and a move to be near their family would increase the support system for both the client and his/her children. An increased support system will aid the participant in finding/keeping employment.

    e. The applicant is a victim of domestic violence and relocating will improve the safety of the client as well as aid in obtaining employment to gain self-sufficiency.

8. Relocation Assistance applicants may be eligible for transitional benefits if relocation occurs within the State of Florida. Relocation outside the State of Florida is subject to operating procedures within that State.

C. Local Policy Requirements

1. Approval or disapproval of an applicant's request for RA will be made by the Welfare Transition Program (WTP) Manager within 14 calendar days of receipt of the completed relocation request package, including a formal application signed by the applicant.

The decision of approval or disapproval will always be made in the applicant's best interest and based upon reasonable expectations that the move will increase his/her opportunities of becoming self-sufficient.

2. Local Program Referral

a. A WT participant may initiate a Relocation Assistance request with a Career Advisor (CA) at any time. The CA will discuss the information that is required and assist him/her in completing the required RA paperwork.

Once the required paperwork and all supporting documentation has been submitted, an appointment will be scheduled with the WTP/SNAP Manager.

b. If the WT participant requests RA while he/she is completing the work registration process, the participant will be given an appointment with the WTP/SNAP Manager by the front desk.

c. After Section A of Form 2279 has been completed by the WTP/SNAP Manager, Section C of Form 2279 will be read and signed by the applicant. This section explains to the applicant his/her obligations and opportunities as a recipient of RA.

WT will then have 14 calendar days to complete the form with approval or disapproval and return it to DCF.

D. Local Program Procedures

After Section A and Section C of Form 2279 have been completed, the following procedures will be followed by CareerSource Escarosa:

1. WT will determine if the applicant is qualified for the Relocation Assistance. He/she must either be an applicant who is pending or eligible for cash, a current WT participant or a WT participant who has been approved for a hardship extension. For all applicants, WT Staff must complete the AWI 0005 Eligibility for TANF Funded Services form (Exhibit "B") to ensure the family meets TANF eligibility requirements.

   A review of the OSST system and the Inquiry Cash Issuance History (IQCH) and/or the Case Narratives (CLRC) in the DCF FLORIDA system will document the status of the applicant. A WT participant whose time limits have expired or whose case has closed due to employment and who is no longer receiving cash is not eligible to receive RA through the WT program.

2. The WTP/SNAP Manager or CA will explain the Relocation Assistance Program and qualification requirements to the applicant.

3. The WTP/SNAP Manager and CA will document the reason for the relocation assistance by checking the appropriate relocation reason in Section B of the Relocation Assistance Program Checklist (AWI-WTP-2279).

4. If the applicant does not meet eligibility and/or local policy requirements, the WTP/SNAP Manager or CA will explain the reason for disqualification to the applicant and check "None of the Above" to Question 1 and "Relocation Assistance Denied" under the Relocation Assistance Outcome in "Section B".

   The WTP/SNAP Manager will sign and enter the date completed. The Relocation Assistance Program Checklist will then be returned to DCF.

5. If the applicant does meet all eligibility and policy requirements, the CA will document the criteria for which the relocation assistance is

being considered in "Section B" of Form 2279 by checking the box next to the applicable requirements.

6. The WTP/SNAP Manager or CA will explain the Relocation Budget Worksheet Form (Exhibit "C") to the applicant. Although the CA, Customer Service Representatives or WTP/SNAP Manager may assist in completing these forms, completion of the forms is primarily the applicant's responsibility. This ensures that the applicant realizes the seriousness and expense of such a permanent decision.

7. For Domestic Violence victims, the CA or WTP/SNAP Manager will follow the Domestic Violence Procedure Policy, which includes resource information to ensure their safety and prevent exposure to further danger.

8. After RA has been approved, the WTP/SNAP Manager will complete the Relocation Assistance Program Transfer Letter (Exhibit "D") and provide the applicant with two copies. In addition, one copy will be mailed to the nearest workforce or one stop center in the participant's new community and a copy must also be placed in the case file. This letter will introduce the applicant to his/her new community/coalition as a "relocation assistance recipient". This letter also indicates the amount of assistance provided and that this applicant may be requesting assistance with services such as childcare and transportation.

9. The WTP/SNAP Manager will forward the approved Relocation Assistance Program Checklist to DCF. DCF will process the case in accordance with their policies and issue the relocation assistance payment.

10. The WTP/SNAP Manager must monitor the relocation within the first 90 days after the relocation assistance is provided. Monitoring the relocation requires at a minimum that a survey (Exhibit "E") be

sent to the relocated family or the RWB provider can telephone the relocated family and complete the survey by phone. A case note must be entered into OSST with the date and contact information for the completed survey to validate the 90 day follow up. The WTP/SNAP Manager will not be held responsible if the applicant does not act in accordance with the relocation plan.

The number of times an applicant may apply for Relocation Assistance is not limited; however, any subsequent applications will be evaluated to determine why the previous relocation was not successful. This information will be a factor in determining the appropriateness of future relocation assistance.

CHAPTER VIII
RELOCATION PROGRAM

EXHIBITS

- Exhibit "A" – Relocation Assistance Program Checklist

- Exhibit “B” – AWI 0005 Eligibility for TANF Funded Services form
- Exhibit “C” – Relocation Budget Worksheet (6 pages)
- Exhibit “D” – Relocation Assistance Program Transfer Letter
- Exhibit “E” – Relocation Follow-up Survey (2 pages)

RELOCATION ASSISTANCE PROGRAM CHECKLIST

Section A: To be completed by Department of Children and Families or Regional Workforce Board

_____ _____
Name (please print) *Social Security Number

_____ _____(_____)_____ Check one: ☐ Applicant ☐TCA Recipient
Case #/Category/Sequence RFA Date (applicant) AG Size

Section B: To be completed by the Regional Workforce Board

1. Which of the following requirements does the individual meet? (Check all that apply)

- ❑ The individual is unlikely to achieve economic self-sufficiency at the current community of residence.
- ❑ The individual has obtained a job that provides an increased salary or improved benefits that requires relocation to another community.
- ❑ The individual has a family support network that will contribute to job retention in another community.
- ❑ The individual is a victim of domestic violence and would experience reduced probability of further incidents through relocation.
- ❑ The individual must relocate in order to receive education or training that is directly related to the individual's employment or career advancement.
- ❑ Other

  _____

- ❑ None of the above. The individual does not meet the requirements for the Relocation Assistance Program.

2. Does the community receiving the relocated family have the capacity to provide needed services (such as, childcare and transportation) and employment opportunities? ☐ Yes ☐ No

RELOCATION ASSISTANCE OUTCOME (include location):

_____

_____

Check One:

☐ **Approved** Date:_____/_____/_____ ☐**Denied** _____/_____/_____ ☐**Withdrawn by the Applicant/Recipient**

____/____/_____ $_____Total Amount Approved for Relocation Vouchers and Non-EBT Payment (RWB Provision)

$_____Cash Approved for Application to EBT Card (DCF)

_____
Regional Workforce Board Provider (please print) Telephone Number _(_____)_____

_____ _____/_____/_____
RWB Provider Signature Date

Section C: To be completed by the applicant or recipient if approved for Relocation Assistance.

I understand that I may receive Relocation Assistance in the amount of $_____. If I receive relocation assistance, I may not apply for or continue to receive Temporary Cash Assistance for six months, unless an emergency is demonstrated to and approved by the Regional Workforce Board. The Relocation Assistance must be repaid if I reapply for Temporary Cash Assistance within six months due to an emergency, other than domestic violence. **IF I DO NOT RELOCATE OR IT IS DETERMINED THAT FRAUD WAS INVOLVED, THE ENTIRE AMOUNT MUST BE REPAID AND BENEFIT RECOVERY PROCEDURES WILL BE INITIATED.** If I am relocating due to domestic violence, I may apply for Temporary Cash Assistance and related support services once I relocate. If I am relocating in the State of Florida for any other reason, I may receive job search childcare for 30 days from the date I report to the one-stop career center. I may receive transitional support services if I am employed within 90 days of receiving the Relocation Assistance.

___ I agree to have completed the relocation process within 90 days from the date the funds are provided to me through my EBT card or through other payments made by the RWB. I must complete the relocation process or return the funds within 90 days.

Applicants only: I further understand that if I am approved for relocation assistance, I am withdrawing my application for Temporary Cash Assistance. If I am denied relocation assistance, I may be required to reapply for Temporary Cash Assistance.

_____ _____
Applicant's or Recipient's Signature **Date Signed**

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

Eligibility Form for TANF Funded Services

Recipient Name: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

*SSN: _____ Date of Birth: _____

TANF FUNDS MUST BE EXPENDED TO MEET ONE OF THE FOUR PURPOSES OF TANF

1. Provide **assistance** to **needy families** so that children may be cared for in their own homes or the homes of relatives.
2. **End the dependence** of **needy parents** on government benefits by promoting job preparation, work and marriage.
3. Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing these pregnancies.
4. Encourage the formation and maintenance of two-parent families.

Step 1: Citizenship/Qualified Non-citizenship Status

If the TANF program or service eligibility is a means tested benefit (income based), the family member(s) served **MUST** be:

____ An United States Citizen, or

____ A qualified non-citizen

If either line in Step1 is selected, go to Step 2. If neither line is checked, the person or family is NOT eligible for TANF funded services or programs if eligibility is based on income. The following toolbox has been provided to assist in the determination of citizenship/qualified non-citizenship status.

Citizenship and Qualified Non-Citizenship

Citizenship or qualified non-citizenship status is only required for "means tested benefits." This means eligibility for the benefit, program or supportive service is based on income. **If the TANF applicant does not meet a status criteria under Section A , B or C, (s)he is not eligible for TANF "means tested benefits."**

Section A: A United States Citizen is an individual who was born in the United States, born abroad to a United States Citizen meeting specific criteria, or the individual is naturalized. Is the individual/family member a United States Citizen? ☐ Yes ☐ No

Section B: The applicant is eligible if (s)he has one of the following INS statuses:

- **An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA);**
- **An alien who is granted asylum under Section 208 of the INA;**
- **A refugee who is admitted to the U.S. under Section 207 of the INA or a victim of human trafficking (these individuals must have their status verified by the Department of Health and Human Services);**
- **An alien who is paroled into the U.S. under Section 212(d)(5) of the INA for a period of at leat one year;**
- **An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241 (b)(3);**
- **An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980; or**
- **An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.**

Or, is a lawful permanent resident with a prior INS status identified above

Or, is a without a prior INS status listed above, and they were in the U.S. prior to August 26, 1996.

Does the applicant meet one of the above criteria in Section B? ☐ Yes ☐ No

Section C: The individual is eligible if (s)he meets one of the following two circumstances below. Does the applicant meet one of the two circumstances below? ☐ Yes ☐ No

- (S)he is a lawful permanent residents who are without prior INS status (above) and who entered on or after August 22, 1996;
- Or the (s)he is an alien who have been battered or subjected to extreme cruelty, or whose children/parents have been battered or subject to extreme cruelty.

If yes, the family is not eligible until five years after the date of entry. Please provide the date of entry ___/___/_____.

Step 2: Family Definitions

The family requesting services includes:

____ A **parent or relative** caring for one or more **children** (see definition of "child" below)
____ A **pregnant woman,** or
____ A **non-custodial parent** (see definition of "non-custodial parent" below)

Child: a dependent person under 18 (or under 19 who is still a full-time student in high school or at the equivalent level of vocation or technical training), who has never been married or whose marriage was annulled and whose eligibility is being determined.

Parent: includes a mother, father, adoptive mother and adoptive father.

Non-Custodial Parent: the parent is not in the household of the child (see definition for child above) whose eligibility is being considered. Both the non-custodial parent and the child must live in the State of Florida.

Blood Relative: including those of half-blood, within the relationship of siblings, first cousins, nephews, nieces, aunts, uncles and individuals of preceding generations as denoted by prefixes of grand, great, great-great, etc. This group includes relatives within the fifth degree of kinship to the dependent child; therefore, this includes first cousins once removed, but not the second cousins.

If any line in Step 2 is checked, continue to Step 3. If none is checked, the individual is only eligible for services accomplishing/supporting TANF purposes #3.

Step 3: Determination of Need

Depending on the purpose served, program, benefit or service, the family's income level may have to be determined. Although TANF purposes number #3 and #4 do not require a determination of "needy", the RWB or State may restrict benefits and services to individuals and families below a certain income.

A. What TANF purpose does the program, benefit or service accomplish?

_____

B. Does eligibility have income requirements? Note, if TANF purpose number #2 were written above, the answer is "yes." If the program is a State special project, and income requirements are a factor of eligibility, the answer is "yes." If the benefit or service is provided by the Regional Workforce Board through local operating procedures, and the eligibility requirements include income level, the answer is "yes." ☐ Yes ☐ No

C. If yes, does the family meet income eligibility requirements? ☐ Yes ☐ No

If income is strictly based on Florida's definition of "needy":

- Does the family receive Temporary Cash Assistance, relative caregiver program payments, food stamps or are the children in the family eligible for Medicaid? ☐ Yes ☐ No
- Is the family's total income less than 200% of the Federal Poverty Level based on household size? ☐ Yes ☐ No Number of household members: _____

If income is based on reporting instructions, local operating procedures or guidance, please review the appropriate materials for income eligibility determination.

Step 4: Self Attestation

The provider is to review the following statements with the program applicant/participant.

_____Income based or means tested benefits require "family eligibility". I understand that a family member may be designated as a non-applicant, and his/her information regarding citizenship or qualified non-citizenship status will not be required. I understand that my benefits or services will not be delayed if information regarding the non-applicant's citizen status is not provided.

PRIVACY ACT STATEMENT

_____*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

_____If I do not have a Social Security Number and do not know how to apply for one, I understand that I can request help from the One-Stop Career Center or other program provider identified below. The indicated person will refer me to the appropriate agency and may provide other help as needed and requested.

_____ I understand that my Social Security Number will be used to associate all records to my identification, including program participation and the receipt of services and benefits.

I _____ certify, to the best of my knowledge, the above information in this form is true, including income and citizenship/qualified non-citizenship information.

Name: _____ SSN: _____ Date: _____

Signature: _____ Phone Number: _____

Address: _____
Street Address City State Zip Code

_____ _____
RWB provider printed name RWB provider signature

_____ _____
Date Phone Number

RWB Comments: _____

_____

_____

Relocation Screening Form

Applicant's Name (Please print legibly) * _____ **Last Four of SSN** _____

RFA Number _____ **Date Completed** _____

The purpose of relocation assistance is to help you find a job in another area due to lack of support services, greater employment opportunity and/or labor s2rplus. Relocation Assistance requires recipients to remain off cash assistance for six (6) months. Adhere to the following instructions: *Be advised that failure to complete this packet in its entirety will automatically disqualify you from being considered for the diversion.*

1. Complete the Relocation Budget Worksheet in pencil, should you need to make changes.
2. Complete all sections that apply in the Relocation Budget Worksheet.
3. Include a written estimate(s) for each item claimed as an expense in the budget (travel, gas, housing, utilities, etc.).
4. Submit a written statement as to why you are requesting relocation assistance.
5. Verifiable employment verification must be included in this packet.
6. Three (3) personal references must be included [one (1) of which must be in the area that you wish to relocate].
7. Submit a current e-mail address for follow-up.
8. Return all of the above documentation to your assigned Career Advisor (CA) during walk-in hours or at your next appointment (whichever is first).
9. Additional documentation may be required on a case-by-case basis for supervisor approval.

By signing below, I _____ attest that the information submitted is true. I understand that failure to relocate within ninety (90) days, as well as, failure to return the relocation survey will result in a referral for fraud investigation and I also understand that when my employment or demographic information changes (including phone number, address, family members in the home), I will report the information to both the Department of Children and Families and CareerSource Escarosa.

Print Name _____ **Signature** _____ **Date** _____

CHECKLIST

Written Estimate	(Yes)	(No)	**Written Statement**	(Yes)	(No)
Employment Verification Form	(Yes)	(No)	**Personal Reference**	(Yes)	(No)

If "no" on any of the above, packet is not complete.

OFFICIAL USE ONLY

Career Advisor Signature _____ **Date** _____

_____ **Relocation Appointment**

_____ **Relocation Transfer Ltr.**

_____ **Relocation Survey**

RELOCATION ASSISTANCE PROGRAM CHECKLIST

Section A: To be completed by Department of Children and Families or Regional Workforce Board

_____ _____
Name (please print) *Social Security Number

_____ _____ (_____)_____ Check one: ☐ Applicant ☐TCA Recipient
Case #/Category/Sequence RFA Date (applicant) AG Size

Section B: To be completed by the Regional Workforce Board

1. Which of the following requirements does the individual meet? (Check all that apply)

- ❑ The individual is unlikely to achieve economic self-sufficiency at the current community of residence.
- ❑ The individual has obtained a job that provides an increased salary or improved benefits that requires relocation to another community.
- ❑ The individual has a family support network that will contribute to job retention in another community.
- ❑ The individual is a victim of domestic violence and would experience reduced probability of further incidents through relocation.
- ❑ The individual must relocate in order to receive education or training that is directly related to the individual's employment or career advancement.
- ❑ Other

_____

- ❑ None of the above. The individual does not meet the requirements for the Relocation Assistance Program.

2. Does the community receiving the relocated family have the capacity to provide needed services (such as, childcare and transportation) and employment opportunities? ☐ Yes ☐ No

RELOCATION ASSISTANCE OUTCOME (include location):

_____

_____

email address: _____

Check One:

☐ **Approved** Date:_____/_____/_____ ☐**Denied** _____/_____/_____ ☐**Withdrawn by the Applicant/Recipient**

____/___/_____ $_____Total Amount Approved for Relocation Vouchers and Non-EBT Payment (RWB Provision)

$_____Cash Approved for Application to EBT Card (DCF)

_____

Regional Workforce Board Provider (please print) Telephone Number _ (_____)_____

Section C: To be completed by the applicant or recipient if approved for Relocation Assistance.

I understand that I may receive Relocation Assistance in the amount of $_____. If I receive relocation assistance, I may not apply for or continue to receive Temporary Cash Assistance for six months, unless an emergency is demonstrated to and approved by the Regional Workforce Board. The Relocation Assistance must be repaid if I reapply for Temporary Cash Assistance within six months due to an emergency, other than domestic violence. **IF I DO NOT RELOCATE OR IT IS DETERMINED THAT FRAUD WAS INVOLVED, THE ENTIRE AMOUNT MUST BE REPAID AND BENEFIT RECOVERY PROCEDURES WILL BE INITIATED.** If I am relocating due to domestic violence, I may apply for Temporary Cash Assistance and related support services once I relocate. If I am relocating in the State of Florida for any other reason, I may receive job search childcare for 30 days from the date I report to the one-stop career center. I may receive transitional support services if I am employed within 90 days of receiving the Relocation Assistance.

___ I agree to have completed the relocation process within 90 days from the date the funds are provided to me through my EBT card or through other payments made by the RWB. I must complete the relocation process or return the funds within 90 days.

Applicants only: I further understand that if I am approved for relocation assistance, I am withdrawing my application for Temporary Cash Assistance. If I am denied relocation assistance, I may be required to reapply for Temporary Cash Assistance.

_____ _____
Applicant's or Recipient's Signature **Date Signed**

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

Relocation Budget Worksheet

Participant's Name	*Last Four Digits of SSN	Date

The first page provides important direction and information for the relocation assistance applicant. The first page should be reviewed and completed by the applicant in partnership with the RWB provider. The relocation budget worksheet is to be reviewed and completed by both the RWB provider and the relocation applicant. It is the applicant's responsibility to secure estimates and documentation required to complete the relocation process.

Moving Expenses:
Think about the issues involved with a move before you begin to research the costs. To get information about the new community, go to your local library and ask for assistance. You can also access valuable information (i.e. places to live, utilities, local phone services, etc.) using the Internet. You can use the Internet at your local library or at your local One-Stop Career Center. You may also ask if the library has a copy of the local newspaper in the area you wish to move to. The local library should have access to the name and address of the local Chamber of Commerce in the new community. You can write them requesting information and answers to questions you may have. The Chamber of Commerce may also have a web site. Using the Internet, you may be able to find information on employment, services and local business through the Chamber of Commerce's web site.

Areas to Research:

- Employment opportunities
- Available housing (apartments and homes)
- Cost of moving in to or reserving the available housing
- Transportation in the new community
- Childcare in the new community
- The location of the career center
- The shortest route to your new community

The information that you research will be required to complete the relocation process.

1. What is the name of the community (city/state) you wish to relocate to? _____

2. Have you secured employment in the new community? ☐ Yes ☐ No

3. If yes, please provide documentation to the RWB provider. Name of Employer: _____

Phone number of prospective employer: _____ Address: _____

4. If you have not secured employment in the new community, how will the household expenses be met?

_____

5. What is the approximate number of miles to your new location? _____

6. Does the new community offer support services at the one-stop career center through the Welfare Transition program?

a. Childcare ☐ Yes ☐ No
b. Transportation vouchers ☐ Yes ☐ No
c. Education and training assistance ☐ Yes ☐ No

7. Does the new community have other forms of subsidized childcare? ☐ Yes ☐ No
Details: _____

Relocation Budget Worksheet

AWI WTP-0002, December 2006

So that an adequate relocation budget can be developed for your move, you will need to provide at least two estimates for truck rental and motel/lodging expenses. Also, you will need to obtain costs for various modes of travel. After you obtain these costs, complete the chart below.

Moving Truck

Company Name	Company Phone Number	Contact's Name at the Company	Estimate Given by the Company	Date Company was Contacted	Documentation Attached? Y or N
Estimate 1					
Estimate 2					

Personal Travel Expenses

Company Name	Company Phone Number	Contact's Name at the Company	Estimate Given by the Company	Date Company was Contacted	Documentation Attached? Y or N
Estimate 1 Motel					
Estimate 2 Motel					
Gas Estimate					
Airplane Ticket Estimate 1					
Airplane Ticket Estimate 2					
Bus Ticket Estimate 1					
Bus Ticket Estimate 2					

Relocation Budget Worksheet

AWI WTP-0002, December 2006

Housing Estimates

Housing: Type of Housing and Name of Housing Complex	Company Phone Number	Contact's Name at the Company	Estimate Given by the Company (include cost of monthly rent and deposits)	Date Company was Contacted	Documentation Attached? Y or N
Estimate 1					
Estimate 2					
Estimate 3					

Finalized Budget

Main Subject	Type	Subtotal	Name of Company or Explanation of Cost
Moving Expenses			
	Cost of transporting goods (moving)	$	
	Cost of personal and family transportation	$	
	Food during relocation	$	
	Lodging during relocation	$	
		$	TOTAL of Moving Expenses
Housing Expenses			
Transfer fees/deposits:	Electric	$	
	Telephone	$	
	Gas	$	
	Security	$	
	Water	$	
	Other	$	
		$	TOTAL of Housing Expenses
Living and Employment Expenses			
From time to arrival to first paycheck. Estimate costs for at least one month:	Food	$	
	Rent	$	
	Child Care	$	
	Transportation	$	
	Clothing/Uniforms	$	
	Tools/Special Equipment	$	
		$	TOTAL of Living and Employment Expenses
Miscellaneous Expenses			
	Vehicle Registration	$	
	Driver License Transfer	$	
Other describe in detail		$	
Other describe in detail		$	
			Total of Miscellaneous Expenses

Relocation Budget Worksheet

			Expenses

AWI WTP-0002, December 2006

I am requesting relocation for the amount of $_____ (total of all areas).

To be completed by the participant:
Forwarding Address: _____
_____
I can also be contacted through the following individual:
Contact Person Name: _____
Phone Number (____) _____

*To be completed by the **Regional Workforce Board Provider:***

The amount to be provided by DCF, if approved, on the EBT card: $ _____ . _____
and/or
The following amounts will be provided by utilizing local **RWB TANF funds**:

1. Form of payment (voucher, purchase order, purchase card) _____ made to

_____(name of company) for the purpose of _____

_____ (paying first months rent, having the utilities turned on, providing for the movers, transportation, etc) in the amount of $ _____ . _____.

2. Form of payment _____ made to _____for the purpose of

_____in the amount of $ _____ . _____.

3. Form of payment _____ made to _____for the purpose of

_____in the amount of $ _____ . _____.

4. Form of payment _____ made to _____for the purpose of
_____in the amount of $ _____ . _____.

Total Amount: $_____ . _____ provided by RWB utilizing local TANF funds.

_____ _____ _____/____/_____
RWB Provider Printed Name RWB Provider Signature Date of Signature

_____ _____
RWB Provider Address RWB Provider Phone Number

PRIVACY ACT STATEMENT
*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

AWI WTP-0002, December 2006

Relocation Assistance Program Transfer Letter

Please select: ☐ Moving In-State ☐ Moving Out of State

_____ _____
Initiating Regional Workforce Board (please print) Date

_____ (_____)_____
Initiating Regional Workforce Board Provider (please print) Telephone number

_____
Address (please print)

_____

_____

To Whom It May Concern:

As a participant in Florida's Relocation Assistance Program, this letter serves to introduce _____ to you. This participant has relocated from _____ to your area.

The participant has received a lump-sum cash payment of $_____ for relocation. Under Florida law, the participant agrees to remain ineligible for Temporary Cash Assistance for six months, unless the participant meets emergency criteria or relocated due to domestic violence. There is a possibility that the participant may be requesting your help with services such as childcare and transportation.

Please feel free to contact the Regional Workforce Board Provider listed above if you have any questions.

_____ _____
Participant's name (please print) SSN

To be Completed by the Receiving Service Provider:

Please complete the following information and forward the yellow copy to the Initiating Regional Workforce Board (stated above):

_____ (_____)_____
Name (please print) Telephone number

_____ _____
Case Manager's name (please print) Date

_____
Mailing Address (please print)

_____

_____

NOTE TO PARTICIPANT: After relocating, please provide a copy of this letter to your new service provider.

AWI WTP-2278, 6/2004
PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

Careersourceescarosa.com
6913 N. 9th Ave.
Pensacola, FL 32504
P: 850-607-8752 F: 850-476-0935

CHAPTER IX

Support Services

IX. SUPPORT SERVICES

A. General Policies

The CareerSource Escarosa Welfare Transition (WT) program may provide Support Services in accordance with State and local guidelines if funding permits. The WT Career Advisor (CA) will initiate requests for gathering supporting documentation for support services in accordance with established policies and procedures and as noted during the assessments previously conducted or in the participant's WT Individual Responsibility Plan (IRP). Participants must be in full compliance with the WT program by completing all of their assigned hours. Any active pre-penalty on the case renders the case ineligible for support services until the participant is in full compliance.

The participant must be enrolled as a mandatory or transitional WT participant to receive support services. For all SNAP Participants, support services are based upon funding availability. After a participant exits the WT program, Support Services may be granted for up to thirty (30) days if they are employment related. Participants should be counseled and referred to partnering agencies for possible additional assistance.

B. Categories for Support Services

1. <u>Childcare</u>

Childcare assistance will be determined by the Early Learning Coalition (ELC). During the WT Work Registration process, the participant indicates if childcare assistance will be needed for the completion of required work activities. The Childcare Application and Authorization Referral and Acceptance of Childcare Assistance Form (Exhibit "A") must be completed by the CA or appropriate WT staff member and sent to the ELC. All information will be entered into the One-Stop Service Tracking (OSST) system.

Revisions and/or updates regarding the participant's status must be sent to the ELC. Updates, including such items as participant eligibility, activities, and termination, must be completed. A Notice of Change in Childcare Status (Exhibit "B") must be sent to the participant and all parties involved by the CA. All information included on this form must be documented in the OSST system.

The ELC shall be the responsible entity for determining eligibility and the required parent fees for all childcare amounts to be paid.

Transitional Childcare (TCC) may be available to the participant if they meet eligibility requirements. Refer to AWI FG 04-020 OF 21 June 2004 for Guidance concerning transition childcare. ELC will determine eligibility when the referral is received.

2. Transportation

All participants in program compliance will be issued a reloadable Visa Card through Wisely Pay. Participants must complete and sign Exhibit "C" (CareerSource Escarosa Debit Card Agreement) prior to a Visa Card being ordered. The reloadable Visa Card will be mailed to the participant from Wisely Pay. The CA assigned to the participant will order the Visa Card via ADP SmartCompliance system once it has been determined that the client is engaged in and completing their required assigned hours. If the participants are deemed a 2-parent or UP couple, they are both eligible for transportation assistance and each will receive their own Visa Card if they are participating in their own activities. Participants are eligible for transportation assistance if they complete their assigned hours which is verified once they submit their required timesheets by the assigned deadline. Participants must also be in compliance with all program requirements. A participant under a pre-penalty or sanction is not eligible for any support service, including transportation assistance. Any participant not assigned to activities is not eligible for any support service, including transportation. The

CA is responsible for determining who is in program compliance and eligible for transportation assistance. Participants will use their reloadable Visa Card to purchase gas in order to complete their assigned hours each month. Participants that ride the bus are responsible for purchasing their own 30-day bus pass with the funds loaded to their reloadable Visa Card.

Each CA will submit their authorized transportation list to the transportation support staff Wednesday before the 1st and 3rd Friday of each month. The transportation support staff will combine all CA's submissions to one master transportation list, submit it to the accounting Dept, the WTP/SNAP Manager, and then enter the transportation into the OSST Service Plan. The Accounting staff is responsible for verifying and posting the amount in the ADP SmartCompliance system to all approved participants listed on the master transportation list. The Chief Financial Officer has the final approval authority and will transfer all funds from CareerSource Escarosa Bank account to Wisely Pay to cover the total amount of funds needed each month for all approved Visa cards.

These procedures will be monitored by the CareerSource WTP/SNAP Manager to ensure compliance. Accounting will download reports from ADP'S SmartCompliance system as verification of funds spent.

i. Transportation Assistance for 2- Parent/ Unemployed Parent (UP) Couples

If both participants are participating in assigned activities in separate vehicles and have completed all of their hours, they will each receive transportation assistance if they both complete all assigned activity hours based on funding availability.

If both participants are taking turns driving one vehicle to different activities, both participants will receive transportation assistance. If both participants are traveling in the same vehicle and completing their assigned activity hours at the same place, only one participant will receive transportation assistance.

If either one of the UP parents or the couple is under a pre-penalty, transportation is not authorized for either person. If only one UP partner is assigned to activities and the other is not (i.e., medical deferral, stay-at-home parent), only the UP partner who is assigned to activities will receive transportation assistance.

ii. Transportation for SNAP Participants

All SNAP participants who complete their required 80 hours a month and submit appropriate documentation will be authorized a Food Stamp Reimbursement (FSR).

Appropriate documentation must be in the form of a Gas Receipt, Bus Pass or Self Attestation Form. Once Documentation is received the CA will

- Verify all JPR hours first
- Validate and approve documentation to support FSR
- Enter FSR into OSST only for the amount shown on the receipt or Self Attestation form rounded up to the next dollar not to exceed $25.00.

3. Ancillary Expenses

Ancillary costs necessary to comply with countable activities or employment requirements may be provided based upon funding availability. Ancillary Expense Items may Include:

- Uniforms/Clothing/Shoes
- Tools/equipment
- Fees
- Background Checks
- Drug Testing
- Driver's License/ID Card
- Special Needs
- TABE
- Certification/Licensures
- Other as directed and approved by the WT/SNAP Manager (budget permitting)

The above items are those deemed necessary by the employer to obtain or maintain employment or for the participant to maintain work activities and progressively move to self-sufficiency. These costs may be provided for up to thirty (30) days after the participant loses eligibility due to employment-related income.

Under no circumstances will a participant receive any ancillary expense support service if the participant is not in good standing with the WT program. If the participant initiates the process and the case closes due to a work sanction, the participant forfeits the payment, and the check is returned to the CareerSource Escarosa Accounting Department.

a. Uniforms/Clothing

If a participant requests uniforms, tools, etc., for employment, he/she must have their employer sign the Verification of Employment/Loss of Income Form (Exhibit "D") stating that these items are required for the job, that the employer will not reimburse the participant for these items, and that all new hires are required to purchase these items.

If a participant requests appropriate interviewing clothing, the participant must complete a Statement of Need Form (Exhibit "E" page 3 of 3) stating his/her needs. The participant must provide proof of the pending interview.

If there are special needs for a participant on an ETOP site, those needs will be verified from the Career Advisor.

The CA will complete a support services voucher (Exhibit "F") and will state the number of items the participant may need.

The maximum number of items may not exceed the following:

- Two (2) shirts or blouses
- Two (2) pairs of bottoms (includes shorts, skirts, pants or jeans - whichever is required by the employer)
- One pair of shoes within a one (1) year period.
- 1 Blazer or Jacket
- 1 Belt
- 2 Complete Uniforms

The maximum expenditure allowed will be listed on the voucher. The type of clothing allowed for purchase will be determined by the participant's CA and listed on the voucher. The CA will give the voucher to the participant. If the participant should buy legitimate items that are not on the original voucher, the WTP/SNAP Manager will notify the CA via email to approve the extra items (provided the amount does not exceed the amount

specified on the voucher) or to deny the additional items purchased.

The approval email written by the CA will state that the extra items are approved, the reason why they are approved or a denial email with an explanation as to why and how the participant will pay back the disallowed expense. The participant may either reimburse CareerSource Escarosa for the amount owed directly or have their support services suspended (including gas cards) until their debt has been paid. If the participant is now out of the program, the CA will write an email stating that fact and that email will be saved to the participant's file as a "red flag", and that the participant will not receive any type of support services if he/she should re-enter the program until the debt has been paid. A copy of the email (approval, denial, or participant out of program) will be sent to the Support Service Liaison and the email attached to the voucher before forwarding to CareerSource Escarosa's Accounting Dept. The CA will also save a copy to the participant's file.

b. Tools

The WT CA will determine a participant's need for tools by utilizing the Employment/Training Support Verification Form and fill out a Client Services Action Sheet with a detailed justification of needs and the name of the work site. The Client Services Action Sheet will be forwarded to the Support Services Liaison when completed.

The CA will issue a voucher and will specify the detailed list of tools needed. The Support Services Liaison and /or the CA will obtain tools price list from pre-approved vendors.

With the check request, the Support Services Liaison and/or CA will include:

- Three quotes or a justification of why the vendor was chosen
- Voucher
- Receipt/Invoice
- Cash Issuance (IQCH)
- Verification of Employment/Loss of Income Form (Exhibit "D") or other documentation of employment

c. Fees

The CA will determine the need for payment of fees for the participant. Such fees may include GED testing, licensing, and certification testing. If the participant's activity is Vocational Education, the participant must follow those guidelines outlined in Chapter 5.

After a need has been determined, the CA will complete and forward the Client Services Action Sheet with a detailed explanation of the need and the name of the work site to the Support Services Liaison.

The CA and/or Support Services Liaison will prepare a check request and will include:

- Copy of Testing Charges
- Voucher
- Cash Issuance (IQCH)
- Verification of Employment/Loss of Income Form (Exhibit "D") or other documentation of employment

Checks should be made payable to the testing center. Test results will be given to the CA to be saved to the participant's file. Exams will only be paid for once by CareerSource Escarosa

d. Background Checks

The CA will determine the need for background checks, by utilizing the Verification of Employment Form or letter from Employer that the participant has been hired pending a background check and the participant must be responsible for the background check fees. The CA will complete a Client Services Action Sheet with the name of the work site and forward it to the SSS.

The CA will complete a voucher with the WT stamp affixed. The voucher will be given to the participant to take to the vendor at the time of the background check.

The vendor will send the SSS an invoice for the services provided. The SSS will prepare a check request and will include:

- Voucher
- Cash Issuance (IQCH)
- Verification of Employment/Loss of Income Form (Exhibit "E") or other documentation of employment
- Invoice for the Background Check

The Check Request Form will be forwarded to the CareerSource Escarosa Accounting Department for payment.

e. Driver's License/ID Card

Participant may request this assistance via reimbursement after the ID card or License has been purchased or the fee may be paid via check or Wisely Pay Visa Card. A Statement of Need with the original receipt must be submitted with the check request for reimbursement. Only one Driver's License or Florida State ID card is permitted for each mandatory participant. CSE will not pay for any additional fees added onto the driver's license or ID.

f. Special Needs

The CA will determine if a participant has special needs that affect his/her ability to maintain employment or other approved WT activity.

This service is the strictly based upon budget availability. The participant must initiate a request after all other resources have been pursued and denied. The CA then will prepare a memorandum and invoice for review and possible approval of the special need request.

If approved, the Client Services Action Sheet and approved memorandum is forwarded to the Support Services Liaison, along with the supporting documents or copy of the bill.
A voucher or online commitment is sent to the vendor to prevent disconnection of services. The bill, check request, Participant Services Action Sheet, voucher and cash issuance will be forwarded to the CareerSource Escarosa Accounting Dept. for payment.

3. To cancel any voucher that has been requested, submit page 2 of Exhibit "F" to the WT/SNAP Manager or designated person in his/her absence. The support services voucher will then be forwarded to accounting with a copy placed in the participant's case file.

CHAPTER IX
SUPPORT SERVICES

EXHIBITS

- Exhibit “A” – The Childcare and Authorization Referral and Acceptance of Childcare Assistance Form
- Exhibit “B” – Notice of Change in Childcare Status
- Exhibit “C” – Visa Card Agreement
- Exhibit “D” – Verification of Employment/Loss of Income Form
- Exhibit “E” – Statement of Need
- Exhibit “F” – Support Services Voucher

DO NOT WRITE ON THIS FORM

Child Care Application and Authorization

Authorization ☐ INITIAL AUTHORIZATION ☐ REDETERMINATION ☐ UPDATE

If UPDATE, change in: ☐ Hours ☐ Children ☐ Address ☐ Custody ☐ Eligibility Extension ☐ Other

Name of Staff initiating Referral: (Print) ☐ Coordinating Agency ☐ DCF ☐ Welfare Transition Contracted Provider ☐ Privatization Provider

Unit, Number & Address:

City, Zip Code | Phone #:

SECTION A: CLIENT/FAMILY INFORMATION

(Print name, SSN, Date of Birth and Gender. Check appropriate box indicating ethnicity and race, enter letter designation for each race indicated by participant. i.e., (W) White, (B) Black, (A) Asian, (H) Hawaiian and (AI) American Indian. (Use comma to separate each race, i.e., B, A and AI)

RFA #:

Parent/Guardian/Foster Parent/Caregiver Name:(L, F, MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity	Race (Enter letter designations for each race
				☐ Hispanic ☐ NonHispanic	
Spouse's Name: (L, F, MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity	Race (Enter letter designations for each race
				☐ Hispanic ☐ NonHispanic	

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

If there is NO spouse: enter the Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Parent/ (if different from above): (L, F, MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity	Race (Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

SECTION B: ELIGIBILITY

I. Status: ☐ **Assistance** ☐ **Non-Assistance**

☐ **At Risk**: ○ PI ○ PS ○ FS ☐ **Project Safety Net**

☐ In Home ☐ Out of Home: Relative/Non-Relative ☐ Foster Care

☐ **TCA**	☐ **Transitional**	☐ Applicant	X Recipient
☐ Respite	☐ Unemployed Parent	☐ Refugee	
☐ **TCC**	☐ Transitional Education & Training	**TCC Begin Date:**	**TCC End**

II. Purpose of Care

☐ Protection ☐ Therapeutic Plan ☐ TANF At Risk (RCG) ☐ Emergency

☐ Employment ☐ Work Activity ☐ Education Activity

SECTION C: CHILD CARE AUTHORIZATION (Print Legal names of children authorized for care)

Childcare service is authorized for the participant for approved activity(ies) not to exceed a total of ____ hours per week and includes ____ hours transportation time.

Name (F, MI, L)	SSN	DOB (MM/DD/YY)	Gender(M/F)	Ethnicity	Race (Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	

Gross Monthly Family Income: $ ____ TANF: -- FS: -- Attach Documentation (if available)

CHILD CARE AUTHORIZED From ____ Through ____

Comments: ____

SECTION D: AUTHORIZING SIGNATURE(S) certifying accuracy of information.

Applicant Signature: _____ Date: _____

Authorizing Staff Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Coordinating Agency: _____ Date: _____

*****THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE*****

THIS DOCUMENTATION CONTAINS CONFIDENTIAL INFORMATION AND IS PROTECTED BY LAW. IT IS INTENDED FOR USE BY AUTHORIZED USERS ONLY AND WILL BE KEPT AS A PART OF PARTICIPANT'S RECORDS. IT IS NOT FOR PUBLIC DISSEMINATION*

Name (F, MI, L)	SSN	DOB (MM/DD/YY)	Gender(M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	

Welfare Transition Program
Acceptance of Child Care Assistance

NAME: _____

DATE: _____ RFA# _____

By choosing to apply for Temporary Cash Assistance, I understand that I have been referred to the Welfare Transition Program and will be immediately assigned to a work activity for a minimum of 35 hours per week. The Welfare Transition Program will provide childcare assistance so that these activities can be completed.

By signing below, I acknowledge to the following:

1) Participation in the Welfare Transition Program is a ***mandatory*** requirement for receiving Temporary Cash Assistance and I will be required to complete a minimum of 35 hours per week of work activities.

2) I have received a childcare referral. This referral must be presented to Early Learning Coalition during my scheduled appointment.

3) I have received a "What to Bring for Enrollment" and must have all the required documentation necessary to establish childcare when I attend walk in hours at Early Learning Coalition.

4) I must have childcare in place before attending my next scheduled appointment with the Welfare Transition Program.

_____ _____

Staff Signature **Participant Signature**

NOTICE OF CHANGE IN CHILD CARE STATUS

TO:	Date Mailed:
	RFA #:
	SSN:

SECTION A: Your child care is being: ☐ terminated ☐ denied ☐ needs to be redetermined.
You may be eligible to receive continued child care. Contact the child care agency for more information.

Your last day of child care services will be _____ because of the following:

☐ 1. You are no longer eligible for child care for the following reason: _____.

☐ 2. You failed to provide _____ needed to verify your eligibility. If you want your child care to continue, you must provide the items above before your last day of services.

☐ 3. Your authorization ends on the above date, if you want child care to continue please contact _____.

☐ 4. You may be eligible for transitional child care (TCC). Please contact the Department of Children and Families Public Assistance Specialist or the RWB Provider for information on TCC.

☐ 5. Non-payment of parent fees.

☐ 6. Continuation of your child care services needs to be reviewed.

☐ 7. Your child care provider failed to complete the required 3 hour training.

☐ 8. Your child care provider failed the background screening.

SECTION B: CHILD CARE SERVICES FOR THE FOLLOWING CHILDREN WILL BE AFFECTED BY THIS ACTION

Child's Name:	Date of Birth:	SSN or RFA #:

SECTION C: This notice sent by:

Agency:_____ Address:_____ Phone #:_____

Worker's Name:_____ Worker's Signature:_____ Unit #:_____

Copies sent to:
☐ Welfare Transition Contracted Provider
☐ Economic Self-Sufficiency
☐ Protective Services/ Protective Investigations
☐ Child Care Provider
☐ Family Safety & Preservation
☐ Privatization Provider
☐ 4C Agency
☐ Other

SECTION D: Comments: (For agency use only: _____

_____

_____

_____

AWI 5235, SEPT 01 (Replaces CF-FSP 5235, Feb 99) Distribute copies to: RWB Provider, DCF PAS, Child Care Service Provider, and Participant

INSTRUCTIONS FOR THE NOTICE OF CHANGE IN CHILD CARE STATUS FORM

WHEN COMPLETING THE FORM, PLEASE PRINT CLEARLY

INTRODUCTION:
This form is intended to be the universal Notice of Change in Child Care Status form for child care services. It is designed to be used by authorized employees of the Department of Children and Families, Economic Self-Sufficiency and Family Safety and Preservation programs, Welfare Transition Providers and contract providers of these programs.

The person completing the form should indicate the name and address to whom the form is to be sent.

To: Enter client's name and address. **Date Mailed:** Enter date form is completed and mailed.
RFA #: Enter the request for assistance number.
SSN: Enter the social security number.

SECTION A: STATUS
Terminated: Check box if services are being terminated for a current client.
Denied: Check box if the client cannot be enrolled in services.
Redetermined: Check box if services for a current client need to be redetermined.
Note: Referring agencies will check either terminated or denied.
4C agencies will check terminated, denied or redetermined.
Date: Enter last day of child care services. (Allow no more than 10 calendar days before terminating.)
Check the box *to the left of the statement* that applies to the client's situation.
If using 1, 2 or 3, fill in the blanks with the appropriate information.

SECTION B: CHILDREN'S INFORMATION
Child's Name: Enter name of child affected by the action.
Date of Birth: Enter date of birth.
SSN or FLORIDA #: Enter child's social security number.

SECTION C: AGENCY/WORKER INFORMATION
Complete agency name and address in full.
Complete worker's information in full.
Copies sent to: Check appropriate boxes.

SECTION D: COMMENTS
Agency will enter any additional comments.

CareerSource ESCAROSA

CareerSource Escarosa Debit Card Agreement

SSN: _____
DOB: _____
Phone # _____
Email: _____

Debit Card Fee Structure as per Wisely Pay Card Responsibility of card holder/participant	Fees
ATM Withdrawals	$2.00
Cash Advance (Bank Teller Access)	2 % of transaction amount
Convenience Check	$1.50 per check
ATM Balance Inquiries/Declines	$1.00
Point of Sale PIN Transactions	$0.50
Point of Sales Insufficient Funds Decline - PIN decline	$0.50
Point of Sales Insufficient Funds Decline - Signature decline	$0.80
Money Move - Card to Bank	$1.50
Inactivity Fee/ Monthly (After 90 days of no transactions)	$4.95
Point of Sale Signature Transactions	$3.00 + shipping
Cash back from Point of Sale	FREE
Web Online/ Mobile Account Access	FREE
IVR/Live Customer Service Support	FREE
SMS Alerts/Email Alerts/PIN Change	FREE
*Additional Fees are per Cardholder Agreement	Varies

* See Cardholder Agreement and Disclosure Statement that is provided with each card for a list of all fees.

I understand and acknowledge that CareerSource Escarosa has no administrative rights to my debit card and agree to the following:

If the debit card (issued through Wisely Pay) has a balance and is inactive for 90 days, there a monthly inactivity fee of $3.00 deducted from the card balance.
I understand that this fee is my responsibility.

- If I use any of the outlined debit card services for the issued CareerSource Escarosa debit card, the fees as designated above will be automatically deducted from the balance on my card and any additional fees as stated on the Cardholder Agreement.
- If I lose my issued debit card, I am responsible for notifying Wisely Pay Card directly (1-866-313-9029) www.mywisely.com to request a new card.

- Address to send Visa card: _____

_____ _____
Participant Name (Printed) Participant Signature

_____ _____
Case Manager Signature Date

Original signed form to be kept in Participant file and copy given to Participant.

Exhibit "C"

Save | Save & Close | Rename | Cancel | Clear

VERIFICATION OF EMPLOYMENT/LOSS OF INCOME

NOTE: Use the "tab" key to move to the next field.

Date:_____

_____

_____

_____

In order to determine the eligibility of_____for public assistance, please assist us by answering the questions below and returning this form to us by_____.

_____
Case Name

_____
Case Number/Cat/Seq./SSN

Office Address / Phone Number:

Please complete each section which has been marked on Page 1 AND Page 2 of this form.

☐ **Section I – GENERAL INFORMATION**

1. Name of Employee:_____ Social Security Number:_____
   Address:_____
2. Job Title:_____ Type of Work Performed:_____
3. Number of Hours Worked Per Week:_____ Number of Days Worked Per Week:_____
4. A. How often is/was the employee paid? ☐ Day ☐ Week ☐ Bi-Weekly ☐ Monthly
   B. Rate of pay: $_____per_____. ☐ Other _____
   Hr./Day/Wk./etc. (Explain)
5. Date current employment began:_____ Date previously employed:_____
6. Does/did employee receive tips? ☐ Yes ☐ No ***(If yes, please show tips in Section III.)***
7. Is/was employment seasonal? ☐ Yes ☐ No If yes, season begins:_____ ends:_____
8. Is/was the employee covered by health insurance? ☐ Yes ☐ No
   If yes, name of insurance company:_____
9. Number of dependents covered:_____
10. Does/did the employee participate in any type of payroll savings plan or profit sharing? ☐ Yes ☐ No
    If yes, what is the balance? $_____
11. Does the person perform their job duties: ☐ in their home ☐ in your home ☐ N/A

☐ **Section II – LOSS OF INCOME**

1. Date employment ended:_____
2. Reason for termination:_____
3. Is the loss of income ☐ Permanent or ☐ Temporary? If temporary, when do you expect the employee to return to work? _____
4. Date employee received final check:_____ Gross amount: $_____
   (Please list last 4 weeks in Section III.)
5. Will employee receive any vacation pay, retirement refund, or other? ☐ Yes ☐ No
   If yes, what type? _____ Date received:_____ Amount: $_____
6. Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation, or other? ☐ Yes ☐ No If yes:
   A. Name of insurance company:_____
   B. Reason for benefits:_____

☐ Section III – RECORD OF PAY RECEIVED

List the gross amounts and dates of checks or cash, which were paid for the last four weeks in the space below.

Pay Period Ending	Date Pay Received	GROSS Earnings	No. of Regular Hours Worked	Rate of Pay	No. of Overtime Hours	Rate of Pay for Overtime	Tips $$	Earned Income Credit (EIC)

If hours or rate of pay has varied in the above period, please state why.

☐ Section IV – EMPLOYER INFORMATION

Go Back To Page One

What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.

Signature of Employer

Employer's Title

Name of Business

Telephone Number

If applicable, enter "ext." and extension number

Address

Date Completed

CF-ES 2620

WELFARE TRANSITON PROGRAM

STATEMENT OF NEED

Tuition/Books			Special License	
Temporary Shelter			Health Care	
Equipment/Supplies			Uniforms/Work Clothes	
Automobile Expense			Transportation Assistance	
Other			Childcare	

Please Specify Other:

_____

_____

_____

TO: CareerSource Escarosa, Inc. - Welfare Transition Program

Due to my limited income and financial status I am requesting the above marked support service. I have no other available resource or means for meeting this need.

_____ _____

PARTICIPANT NAME RFA# or Last 4 SS#

_____ _____

PARTICIPANT SIGNATURE DATE

This Form May Not Be Back-Dated

To Participant: By signing this form you attest to the fact that there is no other agency or organization pay for this support for you and that you understand the consequences of falsely signing this document.

_____ _____

CAREER ADVISOR SIGNATURE DATE

Exhibit "E"

CareerSource Escarosa
WELFARE TRANSITON PROGRAM

TO ENSURE PROMPT PAYMENT,
PLEASE MAIL ORIGINAL INVOICE AND VOUCHER TO THE ADDRESS BELOW:

VENDOR **DATE:** _____
VOID AFTER 30 DAYS

PARTICIPANT'S NAME **WT NUMBER**

WT ASSIGNMENT: _____

This is to authorize the **WT** participant identified above to purchase only:

_____ Auto Repairs/Supplies	_____ Tools	_____ License/Fees
_____ Clothing (Casual)	_____ Books/Supplies	_____ Medical
_____ Clothing (Professional)	_____ Testing (Assessment)	_____ Uniforms
_____ Transportation	_____ Other _____	

The total purchase is not to exceed: $ _____ _____ . _____

Any purchase amount greater than this will not be paid by CareerSource Escarosa. **To ensure prompt payment, please send this authorization letter and original bill to:**

CareerSource Escarosa / Welfare Transition Program
6913 N. 9th Avenue
Pensacola, Florida 32504

Tax Exempt Number

ITEMS TO BE PURCHASED ONLY

_____ WT/SNAP Career Advisor

_____ WT/SNAP Manager

CareerSource Escarosa
WELFARE TRANSITION PROGRAM

ACTION SHEET

From: _____ Date: _____

To: _____

Participant: _____ RFA: _____

Address: _____

Primary Tel Nr: _____ Alternate Tel Nr: _____

Current /Mandatory Participant (YES/NO) _____

Transitional Participant (YES/NO) _____ Date Transitional Services Began: _____

Job/Activity Site: _____

Support Services Requested:

____ Tuition/Books	____ Automobile Expense	____ Health Care
____ Temporary Shelter	____ Special Counseling	____ Uniforms/Work Clothes
____ Equipment/Supplies	____ Special License	____ Transportation Assistance

____ Other _____

JUSTIFICATION:

Career Advisor Signature: _____

WT Manager Signature: _____

Support Service Signature: _____ Date: _____

Requested Support Service is:

_____ arranged, to take effect on _____

_____ denied: not authorized under CareerSource Escarosa policy and/or federal, state or local statutes/regulations.

_____ pending, under review by higher authority

_____ Other: _____

_____ _____

Assistant Director Welfare Transition Date

CareerSource Escarosa
WELFARE TRANSITION PROGRAM

STATEMENT OF NEED

TUITION/BOOKS		SPECIAL LICENSE	
TEMPORARY SHELTER		HEALTH CARE	
EQUIPMENT/SUPPLIES		UNIFORMS/WORK CLOTHES	
AUTOMOBILE EXPENSE		TRANSPORTATION ASSISTANCE	
OTHER		CHILDCARE	

Please specify other:

_____

_____

_____

TO: CareerSource Escarosa

_____
PARTICIPANT NAME

_____ _____
PARTICIPANT SIGNATURE DATE

_____ _____
CAREER ADVISOR SIGNATURE DATE