

Application for FINANCIAL AID/SERVICES



SECTION I – APPLICANT INFORMATION

Name (First, MI, Last):		Date of Birth	Social Security No*:		Date:
Residence Address:			Mailing Address		
City, State, and Zip Code			City, State, and Zip Code		
Phone	Cell Phone	Alternate Phone	Alternate Cell Phone	E-mail	

Are you a citizen of the United States? <input type="checkbox"/> YES <input type="checkbox"/> NO		If no, are you authorized to work in the U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Males 18 and older - registered for Selective Service? <input type="checkbox"/> YES <input type="checkbox"/> NO		Did you or your spouse serve in the military? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Section IV: Veterans Addendum5.	
What is the highest grade you've completed ? <input type="checkbox"/> <8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Skill Certificate <input type="checkbox"/> Some College <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Masters/Doctorate			

EMPLOYMENT

Are you currently employed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	What is your most recent occupation?	Years of experience in this occupation
Name of employer:	Number of hours per week:	Start Date:	Pay Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Twice/Mo. <input type="checkbox"/> Monthly
If you have more than one employer, add them here:			
If you are employed, have you received a lay-off notice? <input type="checkbox"/> YES <input type="checkbox"/> NO Name of Company?			
If you are unemployed, how did your last job end? <input type="checkbox"/> Quit <input type="checkbox"/> Laid off <input type="checkbox"/> Terminated <input type="checkbox"/> Company Closed			Date job ended:
Are you available to work?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you been unable to find a job in your most recent occupation or industry?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you believe you need services from Workforce Solutions to help you get a better job, or keep a job to support yourself and your family?		<input type="checkbox"/> YES <input type="checkbox"/> NO	What kind of work do you hope to find?
Do you believe you are unsuccessful in your job search because you: <i>(Check all that apply)</i>			
<input type="checkbox"/> don't have a high school diploma, GED;		<input type="checkbox"/> need to improve your interviewing skills;	
<input type="checkbox"/> cannot read or do math well;		<input type="checkbox"/> don't speak English very well;	
<input type="checkbox"/> don't know how to use a computer;		<input type="checkbox"/> lack occupational skills to earn self-sufficient wages;	
<input type="checkbox"/> don't have the skills to successfully job search;		<input type="checkbox"/> other: Explain:	
Do any of the situations apply to your family? You reside with a parent or guardian: <input type="checkbox"/> YES <input type="checkbox"/> NO You reside with friends/family other than parent or guardian: <input type="checkbox"/> YES <input type="checkbox"/> NO		Your current nighttime residence is: Motel, car, or campsite? <input type="checkbox"/> YES <input type="checkbox"/> NO Shelter or temporary housing? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Have any of these agencies determined your family is experiencing homelessness? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> School District <input type="checkbox"/> Transitional Housing Program <input type="checkbox"/> Other Social Service Agency Identify Shelter/School/Social Service Agency:			

*Optional

AN EQUAL OPPORTUNITY EMPLOYER / PROGRAM

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Relay Texas: 1-800-735-2989 (TTY); 1-800-735-2988 (Voice); 1-800-622-4954 (Español)

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ADDITIONAL INFORMATION

Are you now or have you ever been a foster child?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been convicted of a felony or misdemeanor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you consider yourself a run-a-way?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you a teenager who is currently pregnant or parenting?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you a Migrant Seasonal Worker?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have family assets that exceed \$1,000,000.00?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently attending school or training?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If attending high school, name of school:	What grade are you currently in?	
If attending post-secondary school or training, name of school:	No. of class hours/week:	No. of semester credit hours
Have you applied for FAFSA? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you receive scholarships, grants, or loans to help you go to school? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, enter amount, if known: \$
If YES, when did you apply?		
Do you currently receive Workforce Solutions Child Care Financial Assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO	What is the name of your preferred day care provider?	
Race (optional) - Please check all that apply.		
<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian
		<input type="checkbox"/> American Indian or Alaska Native
		<input type="checkbox"/> Hawaiian Native or Pacific Islander
Ethnicity: Hispanic/Latino: <input type="checkbox"/> YES <input type="checkbox"/> NO		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

CHECK ANY BENEFITS YOU (OR A FAMILY MEMBER) RECEIVE NOW OR RECEIVED IN THE LAST SIX OR EIGHTEEN MONTHS:

Now	Last six months	Last eighteen months		<input type="checkbox"/> You	<input type="checkbox"/> Family Member
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Supplemental Nutritional Assistance (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Supplemental Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Social Security Disability Income (SSDI)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Unemployment Insurance	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		Trade Act Assistance (TAA)	<input type="checkbox"/>	
<input type="checkbox"/>			Free or reduced price school lunch	<input type="checkbox"/>	

What are the primary services you are hoping to receive from us?

Help with paying for school or training – Did you discuss with a Career Office Workforce Professional? YES NO

Help with Child Care expenses – Please complete Section V: Addendum for Early Education and Care Expenses

Help with paying for transportation, clothing, etc. to accept or keep a job - Did you discuss with a Career Office Workforce Professional? YES NO

Help with On-the-Job Training/Work Experience–Did you discuss with a Career Office Workforce Professional? YES NO

Other Did you discuss with a Career Office Workforce Professional? YES NO

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SECTION II – FAMILY INFORMATION

Complete the section below about all the people who live in your home. Begin with your information, and then list the people who live with you and their relationship to you. List each person's date of birth and approximate monthly gross income.

Name	Relationship	Dependent of Applicant? Y or N	Date of Birth	Any Income in last six months? Y or N	Gross Monthly Income	Check if this person has a disability <i>*Optional</i>	Check if this person requires child care
1.	Self				\$	<input type="checkbox"/>	<input type="checkbox"/>
2.					\$	<input type="checkbox"/>	<input type="checkbox"/>
3.					\$	<input type="checkbox"/>	<input type="checkbox"/>
4.					\$	<input type="checkbox"/>	<input type="checkbox"/>
5.					\$	<input type="checkbox"/>	<input type="checkbox"/>
6.					\$	<input type="checkbox"/>	<input type="checkbox"/>
7.					\$	<input type="checkbox"/>	<input type="checkbox"/>
8.					\$	<input type="checkbox"/>	<input type="checkbox"/>
9.					\$	<input type="checkbox"/>	<input type="checkbox"/>
10.					\$	<input type="checkbox"/>	<input type="checkbox"/>

If you have more than ten people living in your home, add them here:

I received, read, and signed a copy of the Orientation to Complaint Procedure document. YES NO

DISCLAIMER AND SIGNATURE (IF APPLICANT IS A MINOR, PARENT/GUARDIAN MUST SIGN)

I understand that providing false information or failing to disclose information in order to appear eligible for financial aid is considered fraud. A person, who obtains, or attempts to obtain by fraudulent means, services to which the person is not entitled, may be prevented from receiving future financial aid from Workforce Solutions, will have to pay back financial aid received, and may be prosecuted under applicable state and federal laws.

I certify that my answers are true and complete to the best of my knowledge.

Signature of Applicant

Date

Signature of Parent/Guardian if Applicant is a Minor

Date

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SECTION III – FAMILY INCOME DETAIL

We will likely ask you to provide proof of household income before we award you Workforce Solutions financial aid. Complete this worksheet by listing your household members and checking the income sources that apply to each member within the most recent 26 weeks. If you are applying only for child care assistance, check income sources that apply for the most recent 13 weeks.

Household Member with Income	Wages/ Salary	Self- Employment	UI Payments	Child Support	Interest Dividends	Retirement	Lottery winnings over \$600	Inheritance	Public Assistance (TANF, SSI, SNAP, etc.)	Capital Gains/Loss or Rental Income	Social Security (Old Age, Survivors, Disability)	Workers Compensation
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Acceptable Documentation: (Attach an appropriate document to support each income source for each Household Member)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Pay stubs • Employment/Income Verification form (new job or paid in cash only) • Workers Compensation documentation/statement • Social Security statement • Self-employment verification form • Family or business financial records | <ul style="list-style-type: none"> • Award letter from Veterans Affairs • Bank statement- cannot be used in lieu of pay stubs or income verification • IRS form 1099-DIV, -INT, for dividends or interest • IRS form 1040 Schedule D for capital gains • Retirement/Pension statement | <ul style="list-style-type: none"> • Quarterly estimated tax for self-employed persons (Schedule C) • Supplemental Security Insurance statement (must include benefit type) |
|---|--|---|

The information submitted here is complete and accurate to the best of my knowledge.

Print Name: _____

Signature: _____

Date: ____/____/____

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SECTION III - FAMILY EMPLOYMENT HISTORY

Provide your family's employment history for the six months before the date of this application. Please list all employers you had during this time. Start with your most recent employer. A separate sheet of paper may be used if needed.

Name of Family Member:		Name of Employer:		Employer's Address:		Employer's phone number:	
Start Date: _____	Pay Rate: _____/per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month. <input type="checkbox"/> Year	Number of hours per week: _____	Pay Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Twice/Mo. <input type="checkbox"/> Monthly		Are you currently employed with this company? <input type="checkbox"/> Yes <input type="checkbox"/> No - Last day of employment:		
Name of Family Member:		Name of Employer:		Employer's Address:		Employer's phone number:	
Start Date: _____	Pay Rate: _____/per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month. <input type="checkbox"/> Year	Number of hours per week: _____	Pay Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Twice/Mo. <input type="checkbox"/> Monthly		Are you currently employed with this company? <input type="checkbox"/> Yes <input type="checkbox"/> No - Last day of employment:		
Name of Family Member:		Name of Employer:		Employer's Address:		Employer's phone number:	
Start Date: _____	Pay Rate: _____/per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month. <input type="checkbox"/> Year	Number of hours per week: _____	Pay Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Twice/Mo. <input type="checkbox"/> Monthly		Are you currently employed with this company? <input type="checkbox"/> Yes <input type="checkbox"/> No - Last day of employment:		

I certify that this information is true and complete to the best of my knowledge.

Signature of Applicant

Date

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SECTION IV – VETERANS ADDENDUM

Veterans and Qualified Spouses

Eligible veterans and their qualified spouses receive preference for service when Workforce Solutions has limited resources. Please check a box below if it describes you.

- Federal/State Qualified Veteran** – I served in the active military, naval, or air service and was discharged or released there from under conditions other than dishonorable as specified at 38 U.S.C. 101(2). Active services include full-time duty in the National Guard or Reserve component, other than full-time for training purposes.

Branch:	Component (Active, Reserve, or Guard):	Date entered:
Date discharged:		Type of discharge:
Military occupational specialty (clear text):		
If employed, have you been able to find employment related to your military occupational specialty? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you plan to return to active military service? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Federal Qualified Spouse

- I am the spouse of a veteran who died of a service-connected disability
- I am the spouse of a member of the Armed Forces serving on active duty who at the time of application for priority, is listed in one or more of the following categories and has been so listed for a total of more than 90 days:
 - Missing in action
 - Captured in line of duty by a hostile force, or
 - Forcibly detained or interned in line of duty by a foreign government or power
- I am the spouse of a veteran who has a total disability resulting from a service-connected disability, as evaluated by the Department of Veteran Affairs
- I am the spouse of a veteran who died while a total disability resulting from a service-connected disability, as evaluated by the Department of Veteran Affairs, was in existence

State Qualified Spouse

- I am a spouse who meets the definition of a federal qualified spouse
- I am the spouse of any member of the Armed Forces who died while serving on active military, naval, or air service.

I (print your name) _____ attest that I meet the definition marked above and the associated eligibility criteria. I certify the information stated above is true and accurate to the best of my knowledge, and I understand that if I have misrepresented myself, there may be grounds for immediate termination or services and/or penalties as specified by law. I understand I must report any change in my veteran status to Workforce Solutions within 10 calendar days. I further understand that if the definition marked above is based on a military record that I know is fraudulent, fictitious, or has been revoked, I also may be subjected to penalties as provided in Acts 2011, 82nd Legislature, Chapter 386 (SB 431), as codified in Texas Penal Code Section 32.54.

Signature of Applicant

Date

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**GULF COAST WORKFORCE BOARD
ORIENTATION TO DISCRIMINATION COMPLAINT PROCEDURES FORM
(29 CFR Part 38)**

This Orientation to Discrimination Complaint Procedures form addresses discrimination complaint procedures for the listed programs and services administered in the local workforce development area by the Workforce Development Board and its Contractors:

**Workforce Innovation and Opportunity Act (WIOA)
Temporary Assistance for Needy Families (TANF) / CHOICES
Supplemental Nutrition Assistance Program Employment & Training (SNAP E&T)
Child Care Services (CC)
Trade Adjustment Assistance (TAA) and Trade Readjustment Allowances (TRA)**

THE RECIPIENT OF THE FEDERAL FINANCIAL ASSISTANCE IS:

**Gulf Coast Workforce Board
3555 Timmons Lane
Houston, TX 77227**

**Equal Opportunity (EO) Officer: Bobi Cook
Telephone Number: (713) 627-3200
Relay Texas: 1-800-735-2989/ TTY 1-800-735-2988 (Voice)**

The Gulf Coast Workforce Board (the Board) shall resolve equal opportunity complaints in a fair and prompt manner. Acts of restraint, interference, coercion, discrimination, or reprisal towards complainants exercising their rights to file a complaint under this procedure are prohibited. This procedure applies to all applicants and participants who have cause to file a discrimination complaint related to activities or programs administered by the Board. If you have an equal opportunity complaint concerning any of these programs, you may submit your written complaint to the Board or Contractor EO Officer, as appropriate.

After your equal opportunity complaint has been received, the EO Officer will notify you of the next step in the complaint process. As long as you wish to pursue your complaint, the Board or Contractor will follow the steps described below. You should study the Discrimination Complaint Procedure carefully, and if you feel that the required steps are not being followed, contact the EO Officer. Remember, if you feel you are not being provided enough help at any stage of the complaint process, you should contact:

**Texas Workforce Commission (TWC)
Equal Opportunity Monitoring
101 E. 15th St., Room 242-T
Austin, TX 78778-0001**

**Telephone Numbers:
(512) 463-2400
Relay Texas: 1-800-735-2989
TTY 1-800-735-2988 (Voice)**

EQUAL OPPORTUNITY IS THE LAW

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 (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 the administration of, or in connection with, such a program or activity.

What to do if you believe you have experienced discrimination. If you think 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: the recipient's Equal Opportunity Officer (or the person whom the recipient has designated for this purpose); or the Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210. If you file your complaint with the recipient, you must wait until the recipient issues 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 the recipient 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 the recipient 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 the recipient). If the recipient 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.

PROCEDURES ON HOW TO FILE A COMPLAINT

WORKFORCE INNOVATION AND OPPORTUNITY ACT (WIOA) / TRADE ADJUSTMENT ASSISTANCE (TAA) and TRADE READJUSTMENT ALLOWANCES (TRA):

If you think you have been subjected to equal opportunity discrimination under a WIOA Title I or a TAA/TRA financially assisted program or activity, you may file a discrimination complaint within 180 days from the date of the alleged violation with either the Board/Contractor Equal Opportunity Officer (or designee) or Director, Civil Rights Center (CRC), U.S. Dept. of Labor, 200 Constitution Avenue NW, Room N-4123 Washington, DC 20210. If you file your complaint with the Board or Contractor, you must wait until you receive a written Notice of Final Action or 90 days have passed (whichever is sooner) before you can file with the CRC. If the written Notice of Final Action is not issued within 90 days of the day you filed your complaint, you have 30 days following the 90-day deadline to file a complaint with CRC (that is, within 120 days of the day you first filed your complaint). If you receive a written Notice of Final Action on your complaint but are dissatisfied with the decision, you may file a complaint with CRC. However, you must file your CRC complaint within 30 days of receiving the Notice of Final Action.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) / CHOICES and/or CHILD CARE SERVICES (CC):

If you think you have been subjected to equal opportunity discrimination under a TANF/Choices and/or Child Care (CC) program or activity receiving federal financial assistance, you may file a complaint within 180 days from the date of the alleged violation with either the Board/Contractor Equal Opportunity Officer (or designee) or U.S. Department of Health and Human Services (HHS), the Office for Civil Rights, 1301 Young Street, Suite 1169, Dallas, TX 75202, (800) 368-1019. Those filing complaints against child care program services receiving USDA federal financial assistance may choose to contact the U.S. Department of Agriculture (USDA), Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410. If you file your complaint with the Board or Contractor, you must wait until a written Notice of Final Action is issued or until 90 days have passed (whichever is sooner) before you can file with the U.S. Department of Health and Human Services.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM EMPLOYMENT AND TRAINING (SNAP E&T):

If you think you have been subjected to discrimination under a SNAP E&T financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either the Board/Contractor Equal Opportunity Officer (or designee) or the U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC 20250-9410, (202) 260-1026. If you file your complaint with the Board or Contractor, you must wait either until a written Notice of Final Action is issued or until 90 days have passed (whichever is sooner) before filing with the U.S. Department of Agriculture.

Please do not sign this notice until you have read it and understand its contents.

By my signature below, I acknowledge this orientation to the discrimination complaint procedure and the statement regarding Equal Opportunity Is the Law. I affirm that I have read the *Orientation to Discrimination Complaint Procedures Form* and that I have been given the opportunity to ask questions about its contents. I understand that the One-Stop application form is not a job application; rather, this form is used to determine my eligibility to receive program services and to meet federal reporting requirements. I further understand that failure to provide the requested information may prevent me from receiving services.

Applicant Signature _____

Printed Name _____

Date _____

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SECTION V – ADDENDUM FOR EARLY EDUCATION AND CARE EXPENSES

If you are applying for Financial Aid for Early Education and Care Expenses:

1. Carefully read this document
2. Initial you understand and agree to each responsibility (pages 2 and 3) that will apply to you should we award Financial Aid
3. Sign and Date the Parent Acknowledgement on page 4
4. Submit this form with your Financial Aid Application

Parent Agreement

YOUR RIGHTS

1. You have the right to expect good service from Workforce Solutions.
2. Your request for financial aid will be processed without regard of race, color, national origin, age, sex, disability, political beliefs, or religion.
3. We assure you that we will treat any personal information you give to Workforce Solutions as confidential.
4. If we authorize Financial Aid, you may choose the child care arrangement best meeting your needs, including care provided by a child's relative.
5. If we authorize Financial Aid, you have the right to report a change in work or education/training that may result in an increase in the level of financial aid you receive.
6. If we authorize Financial Aid and you are required to pay a monthly fee to your child care provider, you have the right to report a change in family composition or income which may lower your monthly fee.

YOUR PROVIDER SELECTION

I have chosen the child care provider below for my child(ren). I have contacted the facility and have ensured space is available for my child(ren).

Provider Name: _____

Address: _____

Phone: _____

Child(ren) to attend: _____

Days of care needed: _____

YOUR RESPONSIBILITIES

Workforce Solutions wants you to understand your responsibilities if we determine you are eligible for financial aid for early education and care expenses.

Please read the responsibility statements below, initial each responsibility signifying you understand your responsibility and will comply, and sign in the space provided at the bottom of this document.

If you have questions regarding any of these responsibilities, please contact Workforce Solutions at 1-888-469-5627, select option 3, and then option 2 -- or call 713-334-5980.

1. **Family/Income.** I understand if I qualify for child care financial aid based upon my family's income and size, I must report certain changes in my family's income and/or size to Workforce Solutions within 14 days.

If my family experiences a change in income or family composition that would put my family income above the limits detailed on the Workforce Solutions Web Page (<http://www.wrksolutions.com/for-individuals/financial-aid/financial-aid-for-child-care> - Maximum Family Income to Continue Financial Aid for Child Care), **I must report such change to Workforce Solutions within 14 days.**

Failure to report this information within 14 days may result in disallowed costs I will have to repay.

Important: We can help. If you are not sure if your change in income or family composition would result in your family exceeding the limits on the chart referenced above, you can contact Workforce Solutions and our staff will help determine if your change in income or family status results in your family exceeding the limit.

Parent's Initials _____

2. **Work/Training Education.** I understand I am requesting financial aid for child care so I can work, go to school, or attend job training classes. If I am no longer working, no longer in school, or no longer attending job training classes, **I will notify Workforce Solutions within 14 days of the change.**

Failure to report this information within 14 days may result in disallowed costs I will have to repay.

Parent's Initials _____

3. **Contact Information:** I understand I must report any changes in my family's residence, primary phone number, or email address. **I will notify Workforce Solutions within 14 days of the change.**

Parent's Initials _____

4. **Eligibility Validation.** I understand the information I provide to determine my eligibility is subject to validation through cross-checks against state and federal databases, and that I may be asked to participate in face-to-face interviews and provide original documents to verify my identity and eligibility for child care financial aid.

Parent's Initials _____

5. **Parent Fee.** If I am determined eligible and awarded financial aid, I agree to pay my monthly parent fee to my chosen child care provider. Workforce Solutions assesses a sliding scale fee based on my family's gross income, composition and the number of children in care. I understand that my parent fee may decrease depending on changes in family composition, income or the number of children in care. I can notify Workforce Solutions if I have changes in my family composition, income or number of children in care and Workforce Solutions will adjust my monthly parent fee based on the changes I report. My monthly fee will not exceed the amount listed on this Parent Agreement unless the number of children in care increases.

Parent's Initials _____

6. **Choice of Providers.** I understand if I choose:
- a. **a relative to provide care for my child:** the decision to choose my child's relative is mine alone for which I am fully responsible. I understand that my child's relative is not subject to health and safety requirements required of a regulated child care provider. I am responsible for setting requirements for the care provided by my child's relative. I understand that neither the Houston-Galveston Area Council, through Workforce Solutions nor any of its employees, affiliates or contractors, is responsible for actions or omissions of my child's relative providing child care or for the health and safety of my child.
 - b. **a regulated provider to provide care for my child:** the decision to choose a particular provider is mine alone for which I am fully responsible. I understand neither the Houston-Galveston Area Council, through its Workforce Solutions workforce system nor any of its employees, affiliates or contractors, is responsible for actions or omissions of a regulated provider or for the health and safety of my child.
 - c. **a regulated provider that has earned Texas Rising Star (TRS) certification:** I understand that the TRS designation indicates that a provider has quality standards that exceed State minimum standards and should be considered when choosing a provider to care for my child.

Parent's Initials _____

7. **Reporting Attendance.** If I am determined eligible and awarded financial aid, I understand:
- a. I must use the attendance card to report my child's attendance and absences;
 - b. I can designate up to three individuals as alternate card holders to report attendance/absences on my behalf; and the secondary cardholder must be at least 16 years old, unless the individual is the child's parent;
 - c. I (or my alternate cardholders) must review the receipt generated by the attendance card machine to confirm my child's attendance is approved for the day.
 - d. I must inform Workforce Solutions when my attempt to record attendance is denied or rejected and cannot be corrected at the child care provider site.

Parent's Initials _____

8. **Security Agreement Requirements for the Attendance Card.**

- a. I will not let any other individual, child care provider, or its owner, director, assistant director, or employees possess, accept, or use my card or PIN, (or my alternate cardholders' card or PIN), to perform the attendance/absence reporting function on my behalf.
- b. I will not designate the child care provider staff, owner, director, or assistant director as an alternate cardholder.
- c. I am responsible for any misuse of the attendance card by my alternate cardholders.
- d. I am responsible for informing alternate cardholders of these requirements and their responsibility for using the attendance card.
- e. I will report misuse of my attendance cards and/or PINs to Workforce Solutions.

Workforce Solutions will take appropriate action against anyone who fails to abide by the above security requirements for the attendance card, including denying referrals to a vendor holding a card, moving children to another vendor selected by the parent, withholding vendor payments or reimbursement of costs incurred, recoupment of funds, and may include filing criminal charges with the appropriate authorities.

Parent's Initials _____

PARENT ACKNOWLEDGEMENT

1. I understand that a person, who obtains or attempts to obtain by fraudulent means services to which the person is not entitled, may be prosecuted under applicable state and federal laws.
2. I also acknowledge the Parent Handbook can be found on the [Workforce Solutions](#) website and Workforce Solutions will answer my questions.
3. If I receive Financial Aid from Workforce Solutions, I will ensure my child attends child care on a regular basis. Monthly attendance standards include:
 - a. No more than 5 consecutive absences in a month
 - b. No more than 10 total absences in a month.
4. If I receive Financial Aid from Workforce Solutions, I understand that if my child exceeds sixty-five (65) total absences during my eligibility period, my child will not be eligible for child care services for 12 months from the end of my eligibility period. Absences due to a child's documented chronic illness, disability, or court ordered visitation do not count toward the maximum absences allowed.
5. If I receive Financial Aid from Workforce Solutions, I acknowledge that failure to meet my provider's established attendance policy may result in the provider ending my child's enrollment.
6. I give permission to Workforce Solutions to contact third parties to verify income and family composition or to use information from the financial aid application for identification and verification of income.
7. I acknowledge the information on this Parent Agreement including my: Rights, Provider Selection and Responsibilities. I have the right to request a change in my provider selection.

Parent Signature: _____

Printed Name: _____

Date: _____

Workforce Solutions is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities.
Relay Texas Numbers: 1-800-735-2989 (TDD) 1-800-735-2988 (voice) or 711
Equal opportunity is the law.