Student File Check List

Student Name_____
Email _____
Phone _____

Before Intake Appointment

Forms/Tasks in chronological order

- ☐ First Contact Form
- ☐ DCN Verification Form
- ☐ **Find in MoJOBS**-STOP if unable to find & Contact DWD Tech Support
  866-506-0251 or dwdsupport@ded.mo.gov

At Intake Appointment-paper forms

- ☐ SkillUP Registration Form
- ☐ Assessment/Success/Employment Plan & discuss
- ☐ Video Release Form
- ☐ FERPA
- ☐ Given Labor Statistics -MERIC, O*Net
- ☐ FS-5, complete and send
- ☐ WorkKey Scores
- ☐ Talify Results

At Intake Appointment in MoJOBS

- ☐ SNAP APP completed. Don't exit the SNAP app, click "next", and complete
- ☐ Activity S-20 FNS (or S-10 TANF)

Click "Plan" & complete with student present

- ☐ Objective Assessment Summary

Add

- ☐ Initial Case Note-met with potential student to discuss MCC SkillUP training enrollment

With student/soon after appointment, add

- ☐ Individual Employment Plan (IEP)

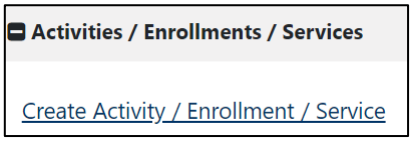
Reverify before 1st day of class.

When class begins add

- ☐ Activity 361, for 90 days

As soon as possible, minimum by end of month in which student begins class-MoJOBS Completion checklist

Add Activities by clicking + sign and clicking "Activities/Enrollment/Services" & click "Create Activity/Enrollment/Service"



- ☐ Activity 101 & case note
- ☐ Activity 107 & case note
- ☐ Activity 205 & case note
- ☐ Activity 213 & case note
- ☐ Activity 142 & case note
- ☐ Activity 141 & case note

As you monitor student progress add

- ☐ Progress Case Note (s)

Add to file:

- ☐ ABAWD only, send FS-5 monthly

- ☐ NCRC-WorkKeys scores, if available
- ☐ Handwritten Case Notes-date, initial
- ☐ Final grades
- ☐ Certificate of Completion
- ☐ Sent FS-5 upon obtaining employment

Post program employment check-in

- ☐ 30 days
- ☐ 60 days
- ☐ 90 days

HAND WRITTEN CASE NOTES: As needed, add a hand written case note, date, & initial re: student's progress or re: MoJOBs needs/errors/concerns.

Transfer written progress notes to MoJOBS.

STLCC SkillUP First Contact Form

Name- First	Name-Last
Telephone #	Address
Date of Birth	Email
Referred By	Last 4 digits SS#
Today's Date	DCN, if known

Please complete the following as part of your initial contact with participant:

1. What type of educational training are you looking for?

2. What is your career goal?

3. Do you have your HS diploma or GED? Yes No

4. Do you want to reduce or eliminate your SNAP benefits with this training?

5. Can you and are you willing to work full-time (after your training ends)? Yes No

6. Are you receiving any other benefits? Yes No

   If yes, by working will this affect your benefits?

7. Are you willing to maintain regular contact via phone, email, and in-person? Yes No

8. Can you think of anything that would keep you from meeting these expectations at this time?

SkillUP Eligibility and DCN Verification Form

(one client per form)

Send to: to DSS.FSD.Agreements@dss.mo.gov

Date:

Client Name: Click here to enter text.

Client Address (Street, City & Zip Code): Click here to enter text.

Client Date of Birth: Click here to enter text.

Client DCN: Click here to enter text.

Comments: Click here to enter text.

Submitted by: Ambrosia Harrison

Requesting Agency: St. Louis Community College

Agency Location: 5600 Oakland Ave., St. Louis MO 63110

Agency Contact Phone#: 314-644-9787

E-Mail Addresses for reply: aharrison58@stlcc.edu
(please include everyone that needs the response or is cc'd)

****

Response from Howell County

Client DCN: 0051738882

ABAWD/Volunteer: Click here to enter text.
(included should be the 3 non-work months for ABAWDs and the reason they are a volunteer, such as child under the age of 18 in the home, etc.)

Food Stamps (FS):

☐ **Pending** ☐ **Regain** ☐ **Active**

Comments:
(or must regain eligibility (give the 3 non-work months) Certification period for food stamp case)

Temporary Assistance (TANF):

☐ **Pending** ☐ **Active**

Comments: Click here to enter text.

REGISTRATION FORM PLEASE PRINT

Office Use Only	Office Use Only
Referral Source ❑ DWD _____ Date ❑ Community Action Agency ❑ Other_____	**Data Entry** ❑ MoJOBs _____ Date ❑ Master Spreadsheet ❑ Other_____ Date ❑ File

Today's date:

STUDENT INFORMATION

Last name:	First:	Middle:	Birth date: / /	Age:	Gender: ❑ M ❑ F
Street address:		City:	State, ZIP Code:		
Contact phone # : ( )	Social Security#:	Email address:			
Ethnicity: ❑ Black, Non-Hispanic ❑ American Indian/Alaskan Native ❑ Asian/Pacific ❑ Hispanic ❑ White, Non-Hispanic ❑ Other	Are you of Hispanic/Latino origin? ❑ Yes ❑ No	Are you a US Citizen? ❑ Yes ❑ No ❑ No, but work authorized If NO, USCIS#_____ Expiration date:_____ Are you an English Language Learner? ❑ Yes ❑ No			

MILITARY/DISABILITY/EMPLOYMENT/SCHOOL INFORMATION

DISABILITY INFORMATION			SNAP ASSISTANCE		
Are you disabled? · Yes · No		*If you have documentation of a disability and want to pursue accommodations, please call 816-604-1000 and ask for an appointment with Disability Support Services at Penn Valley or Business & Technology.*	Are you receiving SNAP Assistance?	❑ Yes ❑ No	DCN #

EMPLOYMENT INFORMATION

Are you currently employed?	❑ Yes ❑ No	If employed, what is your employer's name?
If not employed are you receiving unemployment compensation?	❑ Yes ❑Claimant ❑Exhaustee ❑ No	_____
If yes, what is your occupation? _____		What is your current monthly gross earnings? $_____
If no, what is your career/employment goal?		

MILITARY INFORMATION

Have you completed your Selective Service Registration? ❑ Yes ❑ No ❑ Not Applicable

Are you a US Military Veteran? ❑ Yes ❑ No	Branch of Military Service	From (dates) / /	To (dates) / /	Are You a Spouse of a Veteran? ❑ Yes ❑ No

SCHOOL INFORMATION

Circle below your current educational goal/program of interest:

Non-credit certificate of completion in

Circle one: ACE Personal Trainer Community Health Worker

Customer Information Support Specialist HVAC Operator I

Medical Assistant Patient Care Technician

Truck Driving – Class A CDL Truck Driving – Class B CDL

Highest Educational Level Completed:

❑ Less than HS Diploma/ no GED/HiSet

❑ HS Diploma/GED/HiSet

❑ Some College, no degree

❑ Completed AA/AAS degree

❑ Bachelor's Degree

❑ Graduate Study above Bachelor's

VIDEO RELEASE FORM

I, _____, hereby grant permission to the Missouri Community College Association, the Missouri Department of Social Services, and_____, the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape, without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used for marketing purposes for the SkillUP program in the state of Missouri.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations;
- Online/Internet Videos;
- Media;
- News (Press);

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Street Address/P.O. Box_____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Email Address_____

Signature _____ Date_____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____

6.20.18

WORKFORCE SOLUTIONS GROUP
ST. LOUIS COMMUNITY COLLEGE

SkillUP Grant: Student Success Plan
Assessment/Employment Plan/Student Expectations

Student Name_____ Date_____ Student A# _____

Successful students think in advance about their goals and the realities of their lives to assess if they are ready to succeed and complete their program.

EDUCATION BACKGROUND:

Background: Check highest level of education attained so far:
❒Need to take HiSet
❒HS Diploma/GED /HiSet

❒Some college or Associates Degree in_____

❒Technical/career/trade school Field of study_____

❒Bachelor's Degree or beyond in _____
Learning Challenges: If you have had any challenges learning in the past, please ask about a referral for support services.
**Those with a current degree, certificate or credential in a career field may not be eligible to participate in the SkillUP grant. The decision will be made by the state.*

CAREER/JOB BACKGROUND:

Desired Career Pathway
What is your job/career long term goal?_____
Job Background-fill in all blanks that apply to you:
❒I am not working at this time.
❒I am currently working as _____
Hours: (Circle)
weekends _____am pm to_____am pm
evenings _____am pm to_____am pm
nights _____am pm to_____am pm

Assessing your work schedule, do you have time to attend class? When will you study? _____

REALITIES—X if you have a plan for
☐ Attendance. First key to success is showing up-ATTEND EVERY CLASS!
☐ Transportation –Circle: bus car carpool rides
☐ Childcare/childcare if children are ill
☐ Time for studying outside of class, if required in the program
☐ Support: Who is helping you to succeed? _____
☐ How will you adjust work schedule, if needed?_____

X IF YOU NEED HELP WITH
☐Transportation ☐Childcare ☐School related expenses_____
☐Personal or family challenges you'd appreciate help managing. Your answer is confidential. I'll contact you about this.
☐Any other questions/concerns related to completing you educational goals?_____

STUDENT EXPECTATIONS

I, _____ understand and agree to the SkillUp Grant Employment program rules.
Student's Name-Print

- I will follow my employment plan stated below.
- Once I have completed the program I am aware that I must look for and obtain a job in the field I received my training.
- I also understand it is my job to check-in with my STLCC SkillUP navigator regularly while I am in class, and that the SkillUP navigator will contact me regarding how class is going, ask if I am in need of any help, and direct me to resources for help.
- I understand that the navigator will contact me at 30, 60, and 90 days after I complete the class. The navigator will assist with my job search, obtaining a job, and will ask for my starting wage information.

STUDENT EMPLOYMENT PLAN:

Short Term Training Goal: To obtain enrollment into the program below at STLCC (circle)

ACE Personal Trainer CISS HVAC Operator I Medical Assistant

Patient Care Technician Truck Driving – Class A CDL

Objectives:

- Enroll in program.
- Attend every class session.

Long Term Employment Goal: To obtain a job in the chosen program field and to become self-sufficient without the benefit of government assistances within a year.

Objectives:

- Successfully complete the program.
- Take and pass the state licensing test, if applicable to program
- Search for and obtain a job by contacting employers, completing a resume, filling out online applications, and preparing to interview.

Working Goal: I am looking for my starting pay to be approximately

CDL-A $40,000 yearly CISS $12-15 hr. PCT $10-12 hr. MA $13-15 hr. ACE Personal Trainer $35,000 yearly

HVA Operator $10-15 hr.

to obtain the ability to provide for my family.

_____ _____

Student's Signature Date

_____ _____

Staff Member Date

Missouri Department of Economic Development
Missouri Division of Workforce Development

SkillUP Employment or Training Information

☐ ABAWD
☐ VOLUNTEER
☐ REGAIN ELIGIBILITY

If participant gets Food Stamp benefits, or is attempting to regaining eligibility, and has taken part in work or training in the past 30 days:

- Fill out this form to show participant's work and/or training activities during the past 30 days. Complete as much of this form as you can.
- If there is information you are unable to attain, the Family Support Division (FSD) will contact the participant to obtain additional information. If the participant has questions, they must contact FSD at (855) 373-4636, or visit any FSD Resource Center.
- Attach copies of any papers that confirm participant's activities (such as pay-stubs or school schedule).

Job Center staff: Scan to FSD ABAWD Team and DWD Share Drive.

YOUR INFORMATION

NAME	PHONE NUMBER	DCN *(Required)*	LAST 4 DIGITS OF SSN

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

WORK ACTIVITY #1

NAME	PHONE NUMBER	START DATE	END DATE

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

CURRENT POSITION	AMOUNT EARNED PER PAY PERIOD BEFORE ANY DEDUCTIONS (I.E. TAXES)

PAY PERIOD (CHOOSE ONE)

☐ Monthly ☐ Twice a month ☐ Every 2 Weeks ☐ Weekly ☐ Other

TYPE OF WORK IF APPLICABLE (CHOOSE ONE)

☐ On-the-Job Training ☐ Work Study ☐ Americorps/Visa Stipend ☐ Tips or Bonus
☐ In Kind ☐ Self-Employment ☐ Commission

COMPLETE THE SECTION BELOW FOR EACH PAYMENT YOU HAVE RECEIVED IN THE LAST 30 DAYS

DATE CHECK RECEIVED	RATE OF PAY DO NOT INCLUDED TIPS OR SICK/VACATION PAY	TOTAL HOURS WORKED	EARNINGS BEFORE DEDUCTIONS	TIPS	SICK OR VACATION PAY	OVERTIME AMOUNT INCLUDED IN RATE OF PAY

WORK ACTIVITY #2

NAME	PHONE NUMBER	START DATE	END DATE

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

CURRENT POSITION	AMOUNT EARNED PER PAY PERIOD BEFORE ANY DEDUCTIONS (I.E. TAXES)

PAY PERIOD (CHOOSE ONE)

☐ Monthly ☐ Twice a month ☐ Every 2 Weeks ☐ Weekly ☐ Other

TYPE OF WORK IF APPLICABLE (CHOOSE ONE)

☐ On-the-Job Training ☐ Work Study ☐ Americorps/Visa Stipend ☐ Tips or Bonus
☐ In Kind ☐ Self-Employment ☐ Commission

COMPLETE THE SECTION BELOW FOR EACH PAYMENT YOU HAVE RECEIVED IN THE LAST 30 DAYS

DATE CHECK RECEIVED	RATE OF PAY DO NOT INCLUDED TIPS OR SICK/VACATION PAY	TOTAL HOURS WORKED	EARNINGS BEFORE DEDUCTIONS	TIPS	SICK OR VACATION PAY	OVERTIME AMOUNT INCLUDED IN RATE OF PAY

For additional information about Missouri Division of Workforce Development services, contact a Missouri Job Center near you.
Locations and additional information are available at jobs.mo.gov or (888) 728-JOBS (5627).

Missouri Division of Workforce Development is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Missouri Relay Services are available at 711.

NAME (LAST, FIRST, MI)	**Last 4 SSN and DCN** *(Required)*

TRAINING AND/OR WORKSHOP #1

TRAINING PROVIDER NAME/DWD WORKSHOP NAME *(Required)*	NO. HOURS IN TRAINING PER MONTH	DATES TRAINING STARTS/ENDS
		START _____ END _____

ARE YOU RECEIVING ANY EARNINGS FROM TRAINING?	MO Job Center/WIOA/Partner Agency activity for participation in Employment and Training requirement.	IF TRAINING PROVIDED BY A COLLEGE, LIST NAME AND ADDRESS OF COLLEGE
☐ YES ☐ NO • IF YES, LIST AMOUNT $ _____		
FUNDING SOURCE *(Mark appropriate boxes)*		
SkillUP ____ WIOA ____ Financial Aid ____ Self-Pay ____	YES _____ NO_____	

TRAINING AND/OR WORKSHOP #2

TRAINING PROVIDER NAME/DWD WORKSHOP NAME *(Required)*	NO. HOURS IN TRAINING PER MONTH	DATES TRAINING STARTS/ENDS
		START _____ END _____

ARE YOU RECEIVING ANY EARNINGS FROM TRAINING?	MO Job Center/WIOA/Partner Agency activity for participation in Employment and Training requirement.	IF TRAINING PROVIDED BY A COLLEGE, LIST NAME AND ADDRESS OF COLLEGE
☐ YES ☐ NO • IF YES, LIST AMOUNT $ _____		
FUNDING SOURCE *(Mark appropriate boxes)*		
SkillUP ____ WIOA ____ Financial Aid ____ Self-Pay ____	YES _____ NO_____	

EXEMPTION

I AM NOT AVAILABLE TO WORK OR TRAIN BECAUSE

RECEIVING UNEMPLOYMENT INSURANCE BENEFITS: ☐ YES ☐ NO

OTHER SERVICES

LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
		TOTAL HOURS

You must initial on each of these statements indicating that everything stated is true.

_____ • I understand that it is against the law to obtain or attempt to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

_____ • I authorize the Director of Family Support division or his/her appointee to investigate and verify these circumstances and statements.

_____ • I understand if I disagree with the decision concerning our eligibility, I may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

_____ • I understand that I must report any changes in circumstances within ten days of when they happen.

_____ • I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.

SIGNATURE OF APPLICANT	DATE

FOR INTERNAL USE ONLY

SKILLUP PROVIDER AGENCY AND CONTACT NUMBER	CITY
STAFF NAME	STAFF EMAIL

St. Louis Community College SkillUP

Job Training Progress and Attendance Report

Participant Name:

Expected Completion Date:

Training Location:

SkillUP Project Support Specialist:
Ambrosia Harrison
Email: aharrison58@stlcc.edu

Reporting Period:
From : **To:**

Status:
- o **In Training**
- o **Withdrawal Date: _____**
  Tuition Refund? Y____ N____
- o **Completed Training Date:_____**

Attendance:

P= Present A= Absent T=Tardy
NS= Not Scheduled

S	M	T	W	TR	F	S

% Attendance _____

Test Scores and Certifications

_____
_____
_____

Participant Needs Additional Support From SkillUP?
- o **Yes**
- o **No**

Comments:

_____
_____
_____

Concerns (i.e. soft skills, performance, attitude, behavioral issues):

_____
_____
_____
_____

Training Staff Signature: _____ Date: _____

Please complete this report during training and submit via email to SkillUP Project Support Specialist, Ambrosia Harrison at the following address: aharrison58@stlcc.edu

St. Louis Community College

Student Consent to Release Records

Student name (please print): _____

Social Security/Student Number: _____

I, the undersigned, hereby authorize St. Louis Community College to release the following educational records and information (identify records or types of records):

Assessment Results, Progress Reports, Final Grades, Program Completions, Certifications, Credentials Awarded, Employment

To (Name and Address of Person/Agency to receive Information):

SkillUp (STLCC), SNAP

For the purpose of:

Monitoring and evaluating professional development activities; including participation and progress in non-credit/credit courses.

I understand further that: (1) I have the right not to consent to the release of my education records; (2) I have a right to receive a copy of such records upon request; (3) and that this consent shall remain in effect until revoked by me, in writing, and delivered to St. Louis Community College, but that any such revocation shall not affect disclosures previously made by St. Louis Community College prior to the receipt of any such written revocations.

_____ _____

Student's Signature Date

_____ _____

Parent or Guardian Signature, if student is under 18 Date

This information is released subject to the confidentiality provisions of appropriate state, federal laws and regulations which prohibit any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

MICHAEL L. PARSON, GOVERNOR • STEVE CORSI, Psy.D., DIRECTOR

P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING • JEFFERSON CITY, MO 65102-1527
WWW.DSS.MO.GOV • 573-751-4815 • 573-751-3203 FAX

I give permission to the Department of Social Services, to obtain and use my photograph and/or interview for publication. My signature below indicates that I understand that my name may appear with my photograph or within a written article or video segment.

_____
Print Name

_____
Signature

_____
Date

Missouri Department of SOCIAL SERVICES

Your Potential. Our Support.

RESET

IMPORTANT INFORMATION REGARDING YOUR APPLICATION FOR CHILD CARE SUBSIDY

Including the following documents when mailing or dropping off a child care application, can assist in processing the application in a timely manner:

Citizenship/Relationship

- Citizenship or Immigration Status – if not a United States Citizen, documentation that verifies your legal status in the United States.
- Birth Certificates – if children are born out of state, original birth certificate from the state/country child was born in.

Income

Both earned and unearned income must be verified for all household members included in the eligibility unit.

- Pay check stubs (at least last 30 days and continuous pay periods)
- If new employment, a letter on company letterhead, from the employer stating the number of hours you will be working during a pay period and how often you will be paid. Should also include the date of your first paycheck
- Social Security/Supplemental Security Income – award letter or other verification from the Social Security Administration.
- Child Support income – can usually be verified through the state computer system; however, if you receive child support from a different state, verification will be needed.
- Self-employment – current tax return along with any supporting schedules that were filed.
- Education – documentation for all grants/scholarships/loans you have received to attend school.

If you are uncertain if something is needed to verify income, it is better to submit all documentation/verification you have.

Need for Child Care

To be eligible for child care, there must be a need for all adults in the household or a documented special need for a child. The following are considered valid needs for child care and the verification needed:

- Employment – a copy of your work schedule from your employer, or a letter from the employer on company letterhead, stating the days and hours each day that you work.
- School – A copy of a class schedule to include times and days of week attended. When a class schedule changes a new one must be submitted.
- Training – if you are enrolled in a training through a local agency/program, a copy of the training schedule with days and hours of attendance
- Incapacitated Care Taker – a physician's statement explaining you are unable to care for your child due to a mental or physical disability
- Child with a Special Need for Care – if you do not have a traditional need for care (employment, school, etc.) but have a child that has been classified as having a special need and that child has a special need for care, a medical professional must submit a statement regarding the reason care is needed and the duration of the need for care.

Child Care Provider Name – If you have chosen the child care provider or facility your child will be attending, please provide the name, address, phone number and/or DVN of that provider.

If you need assistance finding a child care provider, you may contact Child Care Aware of Missouri ® at (800) 200-9017 or visit the website at http://mo.childcareaware.org/. You may also visit the Department of Health and Senior Services' Show Me Child Care Provider search at http://health.mo.gov/safety/childcare/.

Social Security Numbers (SSN)

A SSN is NOT required as a condition of eligibility for Child Care Subsidy. Disclosure of SSN is strictly voluntary and will not affect your eligibility for Child Care Subsidy. Child Care Subsidy cannot be denied because you decide that you do not want to disclose your SSN or the SSN for any household member, including children whom benefits are requested. However, if you are applying for other benefits, along with Child Care Subsidy, your SSN may be required.

CHILD CARE APPLICATION

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY user can call 1-800-735-2966. If you are blind or visually impaired and would like information regarding Rehabilitation Services for the Blind, please call 1-800-592-6004.

INSTRUCTIONS: List your address and any phone numbers where you may be reached.

Applicant Full Legal Name		Date	
Home address	City	State	Zip
Mailing address, if different	City	State	Zip

Primary phone number	What kind of phone is this? ☐ cell ☐ home ☐ work ☐ other
Alternate phone number	What kind of phone is this? ☐ cell ☐ home ☐ work ☐ other
Email Address	Preferred method of contact? ☐ *call ☐ text ☐ email ☐ mail *We will call your primary phone unless you note otherwise

INSTRUCTIONS: List all persons who live at your address including yourself. **List yourself first**. Answer all questions about each person.

Full Legal Name (First, Middle, Last)	Date of Birth	Race	Gender	Marital Status	SSN (Optional for Child Care)	Relationship to Head of EU
						Head of Eligibility Unit

Are the above household members Missouri residents and do they intend to remain in Missouri? ☐ Yes ☐ No

If no please explain:

INSTRUCTIONS: List all persons who have earned or unearned income in your household.

Name	Source	Monthly Gross Income	Hourly Pay Rate	Tips Per Pay Period	Pay Frequency

Are you receiving other State or Federal assistance?	☐ Yes ☐ No If yes, explain:_____ amount:_____
Are any changes in income expected?	☐ Yes ☐ No If yes, explain:_____ amount:_____
Do you pay a health insurance premium?	☐ Yes ☐ No If yes, premium frequency: _____ amount:_____
Do you pay a dental insurance premium?	☐ Yes ☐ No If yes, premium frequency: _____ amount:_____
Do you pay a vision insurance premium?	☐ Yes ☐ No If yes, premium frequency: _____ amount:_____
Do you have more than $1,000,000 in assets?	☐ Yes ☐ No

Please provide information concerning your child care provider(s) in the areas provided. Under each provider you list, include the information for each child under that provider's care. Please ensure you list the provider's relationship to each child you list with that particular provider (i.e. grandmother, no relation).

Name of Provider 1	DVN	Phone Number	
Street Address	City	State	Zip
Name of Provider 2	DVN	Phone Number	
Street Address	City	State	Zip

Is your child(ren) enrolled in Early Head Start or Head Start? ☐ Yes ☐ No

Please list the number of days per week each child is in care for each category listed below:

Child's Name (first, middle, last)		5 or more hours		3 to 5 hours		Less than 3 hours	
	Relationship To Provider	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)
1.							
2.							
3.							
4.							
5.							
6.							

THE NEED FOR CHILD CARE IS BECAUSE YOU OR A HOUSEHOLD MEMBER IS: (CHECK **ALL** BOXES THAT APPLY)

☐ employed? Where _____ Phone Number _____ Name _____

☐ attending school? Where _____ Phone Number _____ Name _____

☐ in job training? Where _____ Phone Number _____ Name _____

☐ being evaluated for training and/or employability?
Where _____ Phone Number _____ Name _____

☐ disabled? Can you care for your child(ren) _____

☐ I am homeless (Defined as individuals who lack a fixed, regular, and adequate nighttime residence)

☐ Your child has a "special need" for child care? (i.e. child is classified as having a special need, there is no traditional need for care, but a medical professional has determined the child needs to be in child care.)

- My signature below certifies under penalty of perjury that all information given is true, correct and complete to the best of my knowledge.
- I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.
- I agree to provide any additional information or verification that is requested to determine my eligibility within 15 days of application date.
- I agree to report changes in my income if it exceeds 85% of the State Median income.
- I understand that the statements I have made are subject to investigation and verification.
- I also understand that the laws of Missouri provide for fine or imprisonment or both for persons who knowingly receive or attempt to receive public assistance they are not entitled to or who knowingly fail to report information required to determine eligibility for public assistance.

By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on Page 2. You do not have to consent to this as part of your application. If you want to opt out of getting these calls, check here: ☐

SIGNATURE OR MARK OF APPLICANT: **DATE**

WITNESS TO MARK: **DATE**

ABAWD Exclusions Checklist

- ❑ Receiving unemployment (in any state)
- ❑ Required in the home to care for an ill or incapacitated person
- ❑ Pregnancy in any trimester
- ❑ Temporary or Permanent disability (receives Social Security benefits)
- ❑ Attending drug or alcohol treatment program

Assessment Checklist

- ❑ Participant has the skills and qualifications to participate successfully in training services
- ❑ Participant has the necessary transportation, childcare and other supports needed to be successful in the activity
- ❑ Participant is in need of training services to obtain or retain employment leading to financial independence
- ❑ Participant was placed in activities that align with the Employment Plan
- ❑ Participant has selected a program of training services that is linked to employment opportunities in the local area or an area the individual is willing to commute or relocate
- ❑ Participant is unable to obtain financial assistance from other sources to pay for the cost of training including State funded programs, Trade Adjustment Assistance grant funds, or Federal Pell Grants established under title IV of the Higher Education Act of 1965, or require SkillUP assistance in addition to other sources of grant assistance, including Federal Pell Grants