COMMUNITY ACTION PARTNERSHIP
of NORTHWEST MONTANA

Main Office
214 Main Street
PO Box 8300
Kalispell, MT 59904
T: 758-5454

Libby Outreach Office
933 Farm to Market Rd., Suite B
Libby, MT 59923
T: 293-2712
F: 293-2979

COMMUNITY ACTION PARTNERSHIP ADULT PROGRAM

The goal of Community Action Partnership of Northwest Montana (CAPNM) WIA Title IB, Adult Program is to provide Core, Intensive and Training services to individuals seeking to manage their career needs with access to information and high quality services. This program is intended to empower individuals 18 and older who are at or lower than a level of self-sufficiency through better integration of services and meaningful labor market information (employment statistics) so that individuals can make informed choices about their careers.

All Montana adults are eligible for Core services. Core services include self-help services and services requiring minimal staff assistance.

Intensive and training services may be provided to adults that have been determined to be in need of these services in order to obtain employment, or obtain and retain employment that allows for self-sufficiency. Intensive services may be available to adults who have completed one or more Core Service(s) and are still unable to gain employment or who are employed and have been determined in need of services to get a better job in order to gain self-sufficiency. Intensive services may include individual career planning, resume preparation, career counseling and comprehensive assessments.

Training services may be available for adults who have met the eligibility requirements for intensive services in order to obtain employment. Training services are limited to individuals who are unable to obtain other grant assistance for services, including federal Pell grants. The major emphasis of all services will be to assist those individuals who meet the eligibility and other criteria contained in the Workforce Investment Act (WIA) Manual, in achieving economic self-sufficiency through entry into unsubsidized employment. Training services may include but are not limited to a paid work-experience or occupational skills training. We concentrate on finding employment and training opportunities in areas that will allow Adults to improve our environment and promote the health and well being of our communities.

Income priority of service will be given to those who meet the 80% of Self-Sufficiency Priority of Service Eligibility Verification guidelines (see page 3). Additional Priority of Service will be given to Veterans and Eligible Spouses, Older Workers and those who face a Language Barrier, or face a Cultural Barrier.

CAP WIA Adult Program is an Equal Opportunity Provider and Employer.

• This program is NOT an entitlement program. Due to funding limitations, not everyone who is deemed eligible, will be enrolled in this program. Questions? Call 752-6565
List of Documents Required for Eligibility

The following information and documents are required in order to determine eligibility:

• Copies of documents must be sent in or brought to the CAP Agency with the application. Any required documents not sent in with the completed application will be required before you can be determined eligible for this program.

✓ Application with Release Forms, signed with all appropriate signatures
  Emergency Contact Release Form
  Equal Opportunity Form

✓ Income

One Person household currently employed, and making less than $7.92 an hour is automatically income eligible. If more than one person in household refer to Income table on page 3.

Categorically Income Eligible if receiving TANF cash assistance, food stamps/Commodities or Medicaid – (Social Services award letter, Benefit or Medicaid Card)

✓ Proof of ALL Family Income for the past 26 Weeks (6 Months)
  Most recent paycheck stub(s)
  Employer Statement
  Copy of Social Security check or award letter
  Farm/business records
  Retirement income statement, check, or bank statement
  Public Assistance records
  Statement of Self-Employment income showing income and expenses
  Applicant Statement

✓ Proof of Age - One of the following
  • Birth Certificate
  • DD-214
  • Baptismal Certificate
  • Public Assistance Record
  • School/State ID card
  • Current US Passport
  • Native American Tribal Document
  • Driver’s License or Learner’s Permit
  • Hospital Record of Birth
  • Work Permits

✓ Proof of United States Citizenship - One of the following
  • Birth Certificate
  • Current US Passport
  • Certification of Naturalization
  • DD-214 (if place of birth is listed)
  • Alien Registration Card
  • Hospital Record of Birth
  • Public Assistance/Food Stamp records
  • Baptismal Certificate (if place of birth is listed)
  • Native American Tribal Document
  • Foreign Passport (marked eligible to work)

✓ Social Security Number Verification - One of the following
  • Social Security Card
  • DD-214
  • Social Security Administration Document
  (with participant’s name and SSN)
Eligibility Guidelines for the Community Action Partnership
Adult Program

CAP ADULT PROGRAM services are open to Flathead & Lincoln County residents, age 18 and older who are determined to be low income.

1. WIA Adult Program Income Guidelines

FAMILY is defined as two or more persons related by blood, marriage or decree of court, which are living in a single residence. An adult is categorically income eligible if receiving TANF Cash assistance, Food Stamps/Commodities or Medicaid.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Annual Non-Metro Area</th>
<th>6 Months Non-Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,890*</td>
<td>$5,445*</td>
</tr>
<tr>
<td>2</td>
<td>$15,036</td>
<td>$7,518</td>
</tr>
<tr>
<td>3</td>
<td>$20,644</td>
<td>$10,322</td>
</tr>
<tr>
<td>4</td>
<td>$25,481</td>
<td>$12,740</td>
</tr>
<tr>
<td>5</td>
<td>$30,073</td>
<td>$15,036</td>
</tr>
<tr>
<td>6</td>
<td>$35,172</td>
<td>$17,586</td>
</tr>
</tbody>
</table>

*Explanation of Income Table
The table is a combined listing of 70 percent of Lower Living Standard Income Levels (LLSIL) and OMB Poverty Guidelines. The figures are annualized (12-month) incomes. The figure marked with an asterisk (*) is from the poverty guidelines published by Health and Human Services; the remainder is from LLSIL figures for non-metro areas.

2. WIA ADULT PRIORITY FOR SERVICE

All Adults must meet the income eligibility criteria in order to be enrolled in the WIA Title I Adult program. Priority for services shall be given to recipients of public assistance and low-income. Further consideration may be given to individuals who are at less than 80% of self-sufficiency (80% is currently $7.92/hr) and have a barrier to self-sufficiency such as:

- Veteran; or
- Spouse of a Veteran; or
- Are older workers (55+); or
- Face language barriers; or
- Face cultural barriers; or
- Other individuals who are not receiving services from other programs in WIA
CAP ADULT SERVICES PROGRAM APPLICATION

GENERAL INFORMATION:

DATE: __________________________________________

Last Name _________________________________First Name ____________________________ M.I. _________

Social Security # __ __ __ - __ __ - __ __ __ __                  Date of Birth _________/_________/_________

Street Address          Mailing Address

City ________________________________ State ________ Zip Code _____________ County ________________

Phone (__ __ __) __ __ __ - __ __ __ __               Cell Phone (__ __ __) __ __ __ - __ __ __ __

Message Phone: (__ __ __) __ __ __ - __ __ __ __             Additional Cell Phone (__ __ __) __ __ __ - __ __ __ __

Sex: Male _____ Female_____ E-mail Address: ______________________________________________________

Are you a US Citizen?  Yes __ No __        if not, are you authorized to work in the United States Yes __ No__

Explain, please:  ________________________________________________________________________________

ETHNICITY:  □ White (not Hispanic)   □ Black or African American      □ Hispanic or Latino
□ Alaskan/American Indian □ Asian (not Hispanic) □ Hawaiian/Pacific Islander □ Other

Note: Ethnicity question is voluntary. Information will be kept confidential and is intended for use solely in connection with record keeping and affirmative action requirements. You will not be penalized for refusal to answer.

EDUCATION:

Are you currently in school? Yes ___ No ___ please circle your grade level  7  8  9  10  11  12  13  14  15  16

What school are you (or were you) attending? _________________________________


Receive a High School Diploma or GED? Yes _____ No _____

Attend Vocational School? Yes _____ No _______   Attend/Attending College? Yes ____ No _____

Years of Post Secondary Education Completed   13   14   15   16   16+   Degree?___________________

ADDITIONAL INFORMATION (please complete as this information assists in the eligibility process):

Do any of the following pertain to you?

Are you pregnant? Yes ___ No ____ Are you a parent? Yes ___ No ____ If yes, how many children? _____

Have you ever been involved with the Justice System, Probation System or convicted of any crime except
for minor traffic violations?  Yes _______ No_______ If yes, who is your probation officer?

______________________________________________________

Do you have a valid Montana driver’s license? Yes ____ No ____ If not Montana, what state? ______________

What is your mode of transportation to a job or appointment?  Public Transportation_____________________

Own Car __________ Other ______________________________________________________________________

Were you referred to the WIA program through Unemployment Insurance   Yes ___ No ____

Registered with Job Service? Yes ____ No ____ Registered with Selective Service? Yes ____ No ____**

**If No, you MUST be registered for the Selective Service in order to participate.
Please list all people living in the household who are related to the applicant by blood, marriage, or adoption, their age, relationship to the applicant, and their gross earnings, if any, from the previous 6 months.

**PLEASE INCLUDE YOURSELF ON THE FIRST LINE!**
Documentation of the income may be sent with this application or must be provided at the eligibility interview.

1. Name ______________________________________ Age _____ Relationship SELF
   Social Security # __ __ __ - __ __- __ __ __ __
   Earnings $________________________per wk/mo

2. Name ______________________________________ Age _____ Relationship _________________
   Social Security # __ __ __ - __ __- __ __ __ __
   Earnings $________________________per wk/mo

3. Name ______________________________________ Age _____ Relationship _________________
   Social Security # __ __ __ - __ __- __ __ __ __
   Earnings $________________________per wk/mo

4. Name ______________________________________ Age _____ Relationship _________________
   Social Security # __ __ __ - __ __- __ __ __ __
   Earnings $________________________per wk/mo

5. Name ______________________________________ Age _____ Relationship _________________
   Social Security # __ __ __ - __ __- __ __ __ __
   Earnings $________________________per wk/mo

6. Name ______________________________________ Age _____ Relationship _________________
   Social Security # __ __ __ - __ __- __ __ __ __
   Earnings $________________________per wk/mo

Household size including yourself _____________

☐ Additional listed on back (if necessary)

Are you or any family member presently receiving (Check all that apply and indicate the amount received monthly)?

- Cash Welfare Assistance? $ ______________________________ per month
- Food Stamps or other income support? $ ______________________________ per month
- Social Security Retirement Benefits $ ______________________________ per month
- Social Security or Private Disability $ ______________________________ per month
- Supplemental Security Income (SSI) $ ______________________________ per month
- VA Retirement Pension $ ______________________________ per month
- Death Benefits $ ______________________________ per month
- Alimony $ ______________________________ per month
- Child Support $ ______________________________ per month
- Rental Income $ ______________________________ per month
- Unemployment Insurance Benefits $ ______________________________ per month
CERTIFICATION:
I certify that the information provided in this application packet is true to the best of my knowledge. I understand this information is used to determine eligibility and I may be required to document the accuracy of this information. This information is subject to external verification and may be released for such purposes. If found ineligible after enrollment, I understand I will be terminated from the program. If I am terminated as a result of falsifying information on this application, I understand I may also be prosecuted for fraud. My signature serves as giving permission to verify any and all information contained in this application and the attached forms in the application packet. I acknowledge that I may be asked to provide follow-up information to assist in evaluation of this program.

Applicant Signature ___________________________________________________ Date __ ___/ __ ___/ __ ___

WORK HISTORY:
Are you currently employed? Yes ____ No____ If yes, list employer, employment start date and wage.

Current employer ___________________ Start Date ______/_____/______ Current Wage $________

List all employers and work history below:

<table>
<thead>
<tr>
<th>Employer</th>
<th>Job Title</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
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Reason for leaving _________________________________________________________________
Job Duties________________________________________________________________________

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<tr>
<th>Employer</th>
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<th>Address</th>
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<th>State</th>
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</tr>
</tbody>
</table>

Reason for leaving _________________________________________________________________
Job Duties________________________________________________________________________
### REFERENCES

#### Work Related
Name __________________________________________
Address _______________________________________
City/State___________________ Relationship ________________ Phone # __ __ __ - __ __ __- __ __ __ __

#### Work Related
Name __________________________________________
Address _______________________________________
City/State___________________ Relationship ________________ Phone # __ __ __ - __ __ __- __ __ __ __

#### Personal Reference
Name __________________________________________
Address _______________________________________
City/State___________________ Relationship ________________ Phone # __ __ __ - __ __ __- __ __ __ __

#### Personal Reference
Name __________________________________________
Address _______________________________________
City/State___________________ Relationship ________________ Phone # __ __ __ - __ __ __- __ __ __ __

### GOALS:
What steps do you think you need to take to increase your opportunities of getting a job, getting a better job, or keeping a job?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What is your long term employment goal?
_______________________________________________________________________________________________

Do you feel you have a need for additional training to achieve this goal?
_______________________________________________________________________________________________

How do you feel this program can help you?
_______________________________________________________________________________________________

Do you want to continue living in the same community you currently live in?  Yes ________ No________

If NO, where do you want to live?
_______________________________________________________________________________________________

Do you have any personal goals you wish to share?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
SKILLS, INTERESTS & ABILITIES:

• List skills and abilities that you have used in school, your current or past employment. For example; Customer service, Construction skills, Office work, Auto mechanic, Management, etc. Also please list any all computer and technology skills you may have.

____________________________________________         _______________________________________________
____________________________________________         _______________________________________________
____________________________________________         _______________________________________________

• Do you speak any languages other than English? YES _______ NO _______
What language? _____________________________         _______________________________________________

• List any social memberships you have or volunteer work you do.

____________________________________________         _______________________________________________
____________________________________________         _______________________________________________
____________________________________________         _______________________________________________

• Do you have any hobbies, if so please list them?

____________________________________________          ______________________________________________
____________________________________________          ______________________________________________
____________________________________________          ______________________________________________

• What do you do in your spare time?

☐ Walk/jog, Exercise ☐ Talk with friends ☐ Make craft projects ☐ Yard Work
☐ Play video games ☐ Play Sports ☐ Auto Mechanics ☐ Cook/bake
☐ Read ☐ Wood Working ☐ Small engine repair ☐ Other __________

• If you desire to change employment do any of the following interest you?

☐ Office Work ☐ Truck Driving ☐ Nursing Home ☐ Day Care
☐ Construction ☐ Maintenance ☐ Retail ☐ Cafeteria
☐ Working Outdoors ☐ Other ____________________________ ☐ Other ____________________________

• Do you prefer?

☐ I prefer to work with people ☐ I prefer to work by myself ☐ I prefer to work with the elderly
☐ I prefer to work with a group ☐ I prefer to work with children ☐ I prefer to work indoors
☐ I prefer to work outdoors ☐ I prefer to work with individuals with disabilities
### Agency Release of Information Form

I hereby authorize the release of information to or by Community Action Partnership of Northwest Montana (CAP) with the agencies listed below in order to determine eligibility and to provide complete and proper Case Management Services. I understand that the release will allow communication at needed intervals. I understand that this release will be updated as needed and may be revoked by me at any time with written notification. Also, I understand that I may cross out any agency that I do not wish CAP to share information with.

<table>
<thead>
<tr>
<th>Applicants Name (Please Print)</th>
<th>Date</th>
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</table>

Signature

### AGENCIES

- County Probation
- County Dept of Social Services
- County Dept of Health and Human Services/OPA
- County Law Enforcement Agencies
- Worksite Supervisor
- Office of Public Assistance
- WoRC Program Case Manager
- Other:
  - __________________________________________
  - __________________________________________
  - __________________________________________

### Photo Release

I give permission for my photo to be taken at my work experience site, training site or in any other activities sponsored by CAP Agency as part of the Adult Employment Program. These photos may be published in the newspaper, posted or used in reports and publications of CAP.

Signature

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

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 IB of the Workforce Investment Act of 1998 (WIA), 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 WIA Title IB-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 WIA Title IB-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 you have been subjected to discrimination under a WIA Title IB-financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:

The State WIA Title I Equal Opportunity Officer  
Suzanne Ferguson, Montana Department of Labor and Industry  
P. O. Box 1728, Helena, Montana 59624  
e-mail address: sferguson@mt.gov  
(406) 438-3552 / TDD/TTY (406) 444-0532  
Fax: (406) 444-3037

**OR YOU MAY CONTACT THE CIVIL RIGHTS CENTER BY WRITING**

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 state, 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 Civil Rights Center (see address above).

If you do not receive 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 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 you receive a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with the CRC. You must file your complaint with CRC within 30 days of the date on which you received the Notice of Final Action.

I have read and understand the above policy

_________________________________________   _______________________
Print Name of participant   Social Security Number

_________________________________________   _______________________
Signature of participant       Date

Alternate Format for Visual Impairment? Yes___  No___  N/A ___

DOLI is an Equal Opportunity Employer/Program  
Auxiliary aids and services are available upon request to individuals with disabilities