YOUTH PROGRAM PRELIMINARY APPLICATION

Incomplete Applications will not be considered for program enrollment.

South Central Missouri Community Action Agency

APPLICANT MUST COMPLETE IN INK **Telephone: 573-325-4255**

LEGAL NAME: _____
(Last) (First) (Middle Initial) (Maiden)

ADDRESS: _____
(Street) (City) (State) (Zip Code) (County)

EMAIL ADDRESS: PLEASE PRINT: _____
DIRECTIONS TO HOME: _____

_____

_____
(Social Security Number) (Date of Birth) (Age) (Sex M or F) (Phone Number)

1. _____ _____ 2. _____ _____
(Alternate Phone Number) Relationship (Alternate Phone Number) Relationship

Emergency Contact: _____ _____ _____
Name Phone Number Relationship

(Males 18 years of age or older only): Are you registered with Selective Service? Y ( ) N ( )

Race/Ethnic Background: White/Not Hispanic ( ) Hispanic ( ) Black/Not Hispanic ( )
Asian & Pacific Islander ( ) Refugee ( ) American Indian ( )

U.S. Citizen: Y ( ) N ( ) Eligible Non-Citizen: Y ( ) N ( )

Are you currently working with any other youth serving agency? Y( ) N( ) If Yes, please list the agency and service(s) you receive. _____

High School Diploma: Y ( ) N ( ) From What School? _____ Year?_____
G.E.D. Certificate: Y ( ) N ( ) If no High School Diploma or GED, highest Grade Completed: _____
Currently Attending School: Y ( ) N ( ) Name of School _____
College Degree: Y ( ) N ( ) Title of Degree _____ Field of Study: _____
Name of College Attended: _____ City & State of College: _____

Have you ever been arrested? Y ( ) N ( ) If Yes, for what reason(s)? _____
Marital Status: Single ( ) Married ( ) Divorced ( ) Separated ( )
Veteran: Y ( ) N ( ) Branch: _____ From: _____ To: _____
Current Employment Status: Unemployed ( ) Employed Full Time ( ) Employed Part Time ( )
Are you eligible for unemployment insurance? Y ( ) N ( )

Do you acknowledge a disability: Y ( ) N ( ) If Yes, please state disability:_____
If "YES", do you consider this disability a barrier to employment? Y ( ) N ( )

Have you ever worked on any Employment and/or Training Program(s) as a youth or an adult? Y ( ) N ( )
Name of training program and agency you worked with. When? How Long?:_____

_____

How did you find out about our agency, office, and/or services? Who referred you?_____

_____

Number of family members who reside in your home? _____ Please list below all individuals (INCLUDING YOURSELF) residing in your household related to you by blood, marriage or decree of a court:

Name	Date of Birth	Relationship	Employer

NOTE: Family members included in the household above must fall into one of the following categories: 1) A husband, wife and dependent children. 2) A parent or guardian and dependent children. 3) A husband and wife.

Do you have any relatives working in any department of **SCMCAA**? Yes____ No_____
If yes, please give name and relationship. Name: _____ Relationship: _____
Do you have any relatives working for the South Central Workforce Investment Board? Yes____ No___
If yes, please give name and relationship. Name: _____ Relationship: _____

WORK HISTORY - LIST MOST RECENT JOB FIRST-Use another piece of paper if needed

Employer: _____Job Title: _____
Address: _____Earnings from this job in the last 6 months: _____
Job Duties: _____(DATES) From: ____/_____/_____ To: ___/_____/_____
Average # of Hours Worked Per Week _____ Hourly Rate: _____ month/day/year month/day/year
Reason for Leaving: _____

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Reason for Leaving: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I agree to this request by SCMCAA to exchange or release any information regarding eligibility for my education and/or retraining services. Including, but not limited to: attendance, progress, public assistance records, and verification of employment (including rate of pay and dates of employment). I understand that **SCMCAA** can share information with other social service agencies such as, but not limited to, Family Support Division.

I hereby release any person or agency from any liability for information furnished pursuant to this agreement. I understand that this agreement is valid for thirty days from program completion or until **SCMCAA** has completed the necessary follow-up for one year.

I certify that the information given on this application is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and that falsified or fraudulent information may result in the rejection of this application, subsequent termination from the Workforce Innovation and Opportunity Act Youth Program, or prosecution under the law.

APPLICANT SIGNATURE DATE

PARENT/GUARDIAN SIGNATURE DATE
(Required if applicant is under 18 years of age)

"WIOA Youth Program is an Equal Opportunity Program" and "Auxiliary aids and services available upon request to individuals with disabilities"