Columbia Basin College

WORKFORCE EDUCATION CENTER
Student Application

BFET, Opportunity Grant, Worker Retraining, and WorkFirst

APPLICANT INFORMATION (Please print clearly)

Name: _____ **Date:** _____

Preferred Name: _____ **Phone:** _____

Date of Birth: _____ **SSN:** _____ **SID:** _____

Personal Email: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Are you a Washington resident? (Lived in WA 12 months or more): ☐ Yes ☐ No

Have you previously (or currently) received services from any of these programs (at any school)?:

(Check all that apply) ☐ BFET ☐ Opportunity Grant ☐ Worker Retraining ☐ WorkFirst ☐ Disability Support Services

How did you hear about us?: _____

EDUCATION INFORMATION

Program you plan to study at CBC: _____ ☐ BAS ☐ AAS ☐ AA-Transfer ☐ Certificate

Which quarter will you begin: ☐ Fall (September) ☐ Winter (January) ☐ Spring (April) ☐ Summer (June)

Are you planning to enroll: ☐ Full-Time (12 or more credits – approx. 3 classes) ☐ Part-Time (Less than 12 credits)

Are you currently enrolled in classes at CBC?: ☐ Yes ☐ No

Have you created an academic plan with a CBC Completion Coach?: ☐ Yes ☐ No

What is your highest level of education?: ☐ Less than High School ☐ HS Diploma/GED ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Post Bachelor's Degree

If you previously earned a degree, what was your field of study?: _____ Year earned: _____

List all of the colleges and/or universities you have attended: _____

_____

FINANCIAL INFORMATION

Total household income per month (include spouse or parents, if applicable): $ _____ per month

Number of people in your household: _____

Number of adults: _____ Number of children: 0-5 years: _____ 6-12 years: _____ 13-18 years: _____

Are you currently receiving DSHS Cash Assistance: (TANF) ☐ Yes ☐ No

Are you currently receiving Social Security: ☐ Yes ☐ No

Are you currently receiving Veteran's Benefits: ☐ Yes ☐ No

Are you currently receiving DSHS Food Assistance: (Food Stamps) ☐ Yes ☐ No

Have you applied for Financial Aid: (FAFSA/WASFA) ☐ Yes ☐ No

If you have not applied for Financial Aid, would you like assistance with the application: ☐ Yes ☐ No

Are you currently receiving any other forms of Financial Aid: (Scholarships, WIOA, Loans, Etc.) ☐ Yes ☐ No

FINANCIAL INFORMATION CONTINUED

YES	NO	
☐	☐	**Are you currently receiving unemployment benefits?** ☐ WA State ☐ Other state: _____
☐	☐	**Have you exhausted unemployment benefits within the past 4 years?** Date exhausted: _____
☐	☐	**Are you currently working but have received a notice of layoff?** Date of layoff: _____
☐	☐	**Have you been supported by a family member but lost that support?** (i.e. Displaced Homemaker) Date support ended: _____
☐	☐	**Have you been self-employed and experienced a lack of work due to economic factors?**
☐	☐	**Are you a U.S. Military Veteran?** Discharge date: _____
☐	☐	**Are you in active duty status in the U.S. armed services with a less than 18 months to discharge?**

EMPLOYMENT HISTORY

A. Please answer the following questions regarding your CURRENT employment:

☐ Check this box if you are currently unemployed, then skip to **B**.

Employer name: _____ Position title: _____

City, State: _____ Hours per week: _____

Start date: _____ Gross monthly wages: $ _____

Do you need training to continue your current job and have not earned a related certificate/degree?: ☐ Yes ☐ No

When you finish your education, do you plan to use your certificate/degree to leave your current employment for a position related to your training?: ☐ Yes ☐ No

B. Please answer the following questions regarding your PREVIOUS employment: (most recent position)

Employer name: _____ Position title: _____

City, State: _____ Hours per week: _____

Start date: _____ End date: _____

Reason you left this position?: ☐ Quit ☐ Fired ☐ Laid Off / Lack of Work

RELEASE OF INFORMATION AND ATTESTATION STATEMENT

CBC adheres to FERPA regulations regarding privacy and confidentiality of student information. Because the Workforce Education Center is affiliated with other agencies, we will need to share educational and financial aid information. Your signature authorizes CBC to release any and all educational and financial aid information to our partner agencies including DSHS, Employment Security, WorkSource Partners, other Community Agencies, and other colleges. Furthermore, it authorizes the above agencies to release information to CBC.

☐ **I agree to the release of information policy. I certify that the information provided on this document is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and further understand that the above information, if misrepresented or incomplete, may be grounds for immediate termination from any/all of the Workforce Education Center programs and/or penalties as specified by law.**

Enter or sign your name below if you have read and understand the statement above and can certify that you provided accurate and complete information on this form:

Student Signature: _____ **Date:** _____

INDIVIDUALIZED EMPLOYMENT AND EDUCATION PLAN

Name: _____ **SID:** _____

Career Goals - Short-Term 0-2 years: _____

_____

Career Goals - Long-Term 2+ years: _____

_____

Why did you choose this career path? What lead to the decision to choose this career?:

_____

_____

Please list some of your strengths, skills, abilities, and/or interests that relate to this career path and will help you reach your career goals: _____

What are some potential challenges that you may encounter in pursuing your career and educational goals?:

☐ Computer/Internet access ☐ Limited computer skills ☐ Lack of dependable childcare
☐ Disability (physical, mental, or learning) ☐ Limited English proficiency ☐ Lack of reliable transportation
☐ Limited time for school/work/family ☐ No GED or HS Diploma ☐ Lack of family/friend support
☐ Previous academic history/poor grades ☐ Lack of stable housing/homeless ☐ Legal issues or criminal history
☐ Limited/Negative work experience ☐ Finances (including educational costs and/or money management)
☐ Personal health issues/dependent with health issues ☐ Alcohol/drug use/dependency ☐ Other: _____

What are your strategies to ensure that you complete your education and career goals?:

_____

_____

BFET ELIGIBILITY AND PROGRAM REQUIREMENTS

The following are requirements to participate in the Basic Food Employment & Training (BFET) Program:

- Receive Basic Food Assistance from DSHS
- Intend to seek employment of at least 20 hours per week upon completion of your training/education plan
- Follow your approved training/education plan (IEP)
- Discuss your progress with your BFET advisor at least once per month

I, _____, have read the requirements and agree to abide by them.
(print your name)

☐ Yes ☐ No I understand this form and the contents have been explained to me in my primary language.

Student Signature: _____ **Date:** _____

Interpreter Signature: _____ **Date:** _____
(Required if the client does not understand this form in English)

For Office Use Only

Training/Education Plan: Component _____ Hours/Week _____ Component _____ Hours/Week _____

Educational Institution: Columbia Basin College (Pasco, WA) **Degree/Certification:** _____

Program Start Date: _____ **Program End Date:** _____

Recommended services and referrals to address challenges: _____

_____

BFET Advisor Signature: _____ **Date:** _____

☐ Yes ☐ No This form was reviewed/updated during my BFET intake appointment.

Student Signature: _____ **Date:** _____

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Client Identification			
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER (SS#)	
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION		

Washington State Department of Social & Health Services
Transforming lives

Consent

Notice to Clients: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

Consent

1. I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I also grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, by mail, or hand delivery.

   Reason for Disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.

   Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

   - ☐ Health care providers: _____
   - ☐ Mental health care providers: _____
   - ☐ Substance use disorder service providers: _____
   - ☐ Other DSHS contracted providers: _____
   - ☐ Housing programs: _____
   - ☒ School districts or colleges: Columbia Basin College 2600 N. 20th Ave., Pasco, WA 99301
   - ☐ Department of Corrections: _____
   - ☒ Employment Security Department and its employment partners: WorkSource (Career Path/BFET/ESD) 815 N. Kellogg, Kennewick WA 99336
   - ☐ Social Security Administration or other federal agency: _____
   - ☐ See attached list
   - ☒ Other: Other BFET Providers

2. Reason for disclosure: ☐ Continuity of care ☐ Legal ☐ Personal ☒ Other: BFET Eligibility

3. I authorize and consent to sharing the following records and information (check all that apply):
   - ☒ All my client records ☐ Records on attached list
   - ☐ Only the following records
     - ☐ Family, social and employment history
     - ☐ Treatment or care plans
     - ☐ Payment records
     - ☐ Individual assessments
     - ☐ School, education, and training
     - ☐ Mental health care information (specify):
     - ☐ Health care information (specify):
     - ☐ Other (list):

Client Identification		
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER (SS#)

Please note: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Substance Use Disorder

- **This consent is valid for one-year or ☐ until _____ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE		DATE
WITNESS / NOTARY SIGNATURE, IF APPLICABLE	WITNESS / NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

Notice to Recipients of Information: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Instructions for Completing the Consent Forms, DSHS 14-012

Use: Use this form when you need consent to use or share confidential information about a client on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law.

Fill out this form electronically if possible. You must complete **a separate form for each person, including children.** .

Parts of Form:

IDENTIFICATION:

- Name: Provide the name of only one client on each form. Include any former names that client may have used when receiving services.
- Date of Birth: Needed to identify client from persons with similar names.
- Identification Number: Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- Other: Include in this box any additional information that may help to locate records, such as DSHS involved with services, names of family members, or other relevant information.

CONSENT (AUTHORIZATION):

- Reason for disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.
- Agencies or persons exchanging records: This completed form allows: (1) the use and disclosure of confidential information inside DSHS and with the agencies or persons listed; and (2) disclosure of confidential information to DSHS by the outside agencies or persons listed. You may also attach a list of agencies allowed to share information, which the client must also sign.
- Information included: Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii); a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent, if different than one year. The consent will expire in one year unless you identify a different date.
- Understanding: Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit.

SIGNATURES:

- Client: Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- Witness or Notary: A witness or notary may be needed to verify the client's identity if the client does not submit this form in person or if a program requests verification. This person should sign and print his or her name.
- Parent or Other Representative: If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark "other" and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.