Columbia Basin College

WORKFORCE EDUCATION CENTER
Student Application

Student program application for eligibility and services: BFET, Opportunity Grant, Worker Retraining and WorkFirst

APPLICANT INFORMATION

Name: _____ **Today's Date:** _____

Preferred Name (Nickname): _____ **Phone:** _____

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

Address: _____

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

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

Email (please print clearly): _____

EDUCATION INFORMATION

Program of Study: _____ ☐ BAS ☐ AAS ☐ AA ☐ Certificate

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

Will you be attending:

☐ Full-time (12+ credits) ☐ 3/4 time (9-11 credits) ☐ Part-time (6-8 credits) ☐ >Half-time (1-5 credits)

Do you have a high school diploma or GED?: ☐ Yes ☐ No

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

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

Major: _____ Year Earned: _____

If you do not have a degree, how many prior college credits have you earned (from any college/university)?

☐ None ☐ 1-30 ☐ 31-60 ☐ 61-90 ☐ 91 or more ☐ Unsure

List all of the colleges or universities you have attended:

_____

_____

Have you completed an academic plan with a CBC advisor? ☐ 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 ☐ Resource Center ☐ None of these

What programs are you interested in applying for? (Check all that apply)

☐ BFET ☐ Opportunity Grant ☐ Worker Retraining ☐ WorkFirst

How did you hear about us?

_____

_____

FINANCIAL INFORMATION

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

Total Household Size: _____ Number of Adults: _____ Number of Children: _____

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 collecting 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

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

YES	NO	(Check all that apply)
☐	☐	**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 less than 18 months to discharge?**
☐	☐	**Are you currently employed?** Type of work: _____ Employer: _____ Gross Monthly Wages: $ _____
☐	☐	**Do you need training to continue your current employment and have not earned a related certificate/degree?**
☐	☐	**Are you working in a temporary job earning less than you have previously?** Reason you left your previous job? ☐ Quit ☐ Fired ☐ Lack of Work

EMPLOYMENT HISTORY

Beginning with the most recent, provide the past *five years* of employment history. Attach another page if needed.

Employer name: _____ Position title: _____

City, State: _____ Hours per week: _____

Start date: _____ End date: _____

Employer name: _____ Position title: _____

City, State: _____ Hours per week: _____

Start date: _____ End date: _____

Employer name: _____ Position title: _____

City, State: _____ Hours per week: _____

Start date: _____ End date: _____

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:** _____ **Date:** _____

Please describe:

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

Long-Term Career Goals (2+ years): _____

Why did you choose this career path? What led 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 obstacles and challenges that you may encounter in pursuing your career and educational goals?
(Check all that apply)

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

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

BFET ELIGIBILITY AND PROGRAM REQUIREMENTS

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

- Receive Basic Food Assistance from DSHS
- Be able to work at least 20 hours per week upon completion of your training/education plan
- Follow your approved training/education plan (IEP)
- Make contact with your BFET advisor at least once each 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 client cannot understand this form in English)

For Office Use Only

Training/Education Plan: ☐ BG _____ hours/week ☐ BE _____ hours/week

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

Dates of Training: Program Start Date _____ Projected End Date: _____

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

Recommended services and referrals to address challenges:

Student Signature: _____ **Date:** _____

OPPORTUNITY GRANT ELIGIBILITY AND PROGRAM REQUIREMENTS

The following are the requirements to participate in the Opportunity Grant (OG) Program:

- Notify the OG office as soon as you have completed your class registration and prior to any schedule change, including adding or dropping a class
- Attend class(es) regularly and keep up with class assignments
- Make sure the OG office has a workable email address that you will check frequently
- Inform the OG program of any changes in your address or phone number
- Inform the OG program of any academic or personal issues that conflict with your education
- Check-in with the OG office once a month in person, by email or by phone
- Seek and accept employment upon completion of your certificate/degree
- Maintain satisfactory academic progress of 2.0 CUM GPA each quarter with completion of 50% of attempted credits

☐ **I understand the program expectations and my responsibilities as a recipient of the Opportunity Grant program.**

Enter or sign your name below if you have read and understand the statement above:

Student Signature: _____ **Date:** _____

You have completed the application for eligibility and services for the Workforce Education Center programs:
Basic Food Employment & Training (BFET), Opportunity Grant (OG), Worker Retraining (WRT) and WorkFirst (WF)

Please return your completed application to the **Workforce Education Center** at Columbia Basin College:
2600 N. 20th Ave., MS-T1,
T Building, Room 581
Pasco, WA 99301
Phone: 509-542-4719

THE AREA BELOW IS FOR OFFICE USE ONLY

Reviewed By (int): _____ Date: _____

Training Program: _____ ☐ Prerequisites ☐ Certificate ☐ AAS ☐ BAS ☐ AA-DTA

☐ **SUMMER** _____ ☐ **FALL** _____ ☐ **WINTER** _____ ☐ **SPRING** _____ # of credits _____

☐ Courses enrolled are required for training program ☐ Full-time (12+) ☐ 3/4 time (9-11) ☐ Part-time (6-8) ☐ >Half-time (1-5)

Student Transcript (SM5003) (Transcript on Advisor Dashboard): Number of QTRs at CBC _____ Last QTR attended _____

☐ No prior completions ☐ Prior Certificate/Degree _____ Year _____

Of Cr attempted _____ **CUM** Cr Earn _____ GPA _____ **CLVL** Cr Earn _____ GPA _____ Pace of progress: _____%

Credits from another college _____ ☐ Prior Certificate/Degree _____ Year _____

FAFSA/WASFA Date: _____ Academic Year: _____ EFC: $_____ Total Unmet Need: $_____

SAP: ☐ Good Academic Progress ☐ On FA Warning ☐ FA Canceled: Needs _____ credits to become FA eligible

Comments: _____

_____

Coding Check: Verify contact information and coding is correctly entered in HP-UNIX SMS screens

Admissions (SM2001): ☐ Current Name ☐ Current Address ☐ Current Phone(s)

Registration/Admissions (SM4002): Work Attend Code _____ (WRT=80s WF=60s or 70s WRT/WF co-enroll=50s)

Registration (SM7001) (Schedule on Advisor Dashboard): Res ____ Fee ____ Int ____ Prg ____ Purp ___ Typ ____ Adv ___

Student Unusual Action (SM5003): ☐ "B!" for BFET ☐ "OG" for OG ☐ "W!" for WRT (Stop Gap only)

☐ Any other actions blocking registration? _____

Based on application information, this student could be eligible for:

☐ BFET ☐ Opportunity Grant ☐ Worker Retraining ☐ WorkFirst (Share a copy of this application with each potential program)

Client Identification			
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER	
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

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.