

Career Center Supplemental Questionnaire Additional Information & Program Eligibility

Name: _____

NYID #: _____

Please answer these questions to help us determine if you qualify for other Workforce System programs and services. This information is confidential and will only be used to determine further program eligibility, federal reporting requirements for Workforce Innovation and Opportunity Act-funded programs, and affirmative action requirements. We would like you to complete this form so we can help you better. However, answers are voluntary.

Are you or any member of your family receiving any Public Assistance/Low Income? Yes No

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> TANF (Temporary Assistance for Needy Families) | <input type="checkbox"/> Home Relief |
| <input type="checkbox"/> Food Stamps/SNAP | <input type="checkbox"/> SSI (Supplemental Security Income) |
| <input type="checkbox"/> GA (General Assistance State/Local) | <input type="checkbox"/> SSDI (Social Security Disability Insurance) |
| <input type="checkbox"/> RCA (Refugee Cash Assistance) | <input type="checkbox"/> Exhausting TANF within two years |

Low income individual with a total family income that does not exceed the higher of:

- The poverty line, (Family of 1 - \$12,060 annually) OR;
 70% of the lower living standard income level (based on family size and annual income):
Family Size: 2 people - \$17,505; 3 - \$24,031; 4 - \$29,659; 5- \$35,004; other family sizes please ask staff for income levels.

Are you a person with a disability? Yes No Prefer not to answer

Do you have a physical or mental impairment that substantially limits one or more of your major life activities?

If Yes, do you have a:

- | | |
|--|--|
| <input type="checkbox"/> Physical/Chronic Health Condition | <input type="checkbox"/> Hearing-related disability |
| <input type="checkbox"/> Physical/Mobility Impairment | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Mental or Psychiatric disability | <input type="checkbox"/> Cognitive/Intellectual disability |
| <input type="checkbox"/> Vision-related disability | |

Are you a Migrant or Seasonal Farm Worker? Yes No

If "Yes," check one of the following:

- Seasonal Farm Worker:** someone who is or was employed in the past 12 months in farm work of a seasonal or other temporary nature and who can return to their permanent place of residence in the same day. This does not include non-migrant individuals who are full-time students.
- Migrant Farm Worker:** a seasonal farm worker (see above) who travels to the job site and cannot return to their permanent place of residence in the same day. This does not include full-time students traveling in organized groups rather than with their families.
- Migrant Food Processor:** (see Migrant Farm Worker)

Are you a single parent? Yes No

Are you a single, separated, divorced or widowed person who has primary responsibility for one or more dependent children under age 18 (including single pregnant women)?

Are you an ex-offender? Yes No

Were you subject to any stage of the criminal justice process? Do you need help overcoming barriers to employment resulting from a record of arrest or conviction for crimes against persons or property, status offenses or other crimes?

Are you a Displaced Homemaker? Yes No

Have you been providing unpaid services to family members in the home and:

- Depended on the income of another family member but are no longer supported by that income; or are the dependent spouse of a member of the military on active duty and whose family income is significantly reduced due to a deployment, a call or order to active duty, or the death or disability of the member, **AND**
- Are unemployed or underemployed and are having trouble finding or keeping employment.

Are you a Dislocated Worker?

Check all that apply:

- Have you been terminated or laid off, or have you received a notice of termination or layoff from employment, and are you eligible for or exhausted entitlement to unemployment compensation and are you unlikely to return to a previous industry or occupation (due to a lack of related job openings)?
- Have you been terminated or laid off, or received notice of termination or layoff, from employment as a result of any permanent closure of or substantial layoff at a plant, facility or enterprise?
- Were you self-employed, but are now unemployed as a result of general economic conditions in the community in which you reside or because of a natural disaster?
- Are you the spouse of a member of the Armed Forces who is on active duty, and have you experienced a loss of employment as a direct result of relocation to accommodate a permanent change in your spouse's duty station?
- Are you the spouse of a member of the Armed Forces on active duty who meets the criteria of a displaced homemaker?

Are you homeless? Yes No

Do you lack a permanent and suitable nighttime residence? This includes:

- Sharing housing with other persons due to loss of housing, economic hardship or a similar reason,
- Living in a motel, hotel, trailer park or campground due to a lack of other suitable options,
- Living in an emergency or temporary shelter,
- Abandoned in a hospital,
- Awaiting foster care placement, or
- Having a main nighttime residence that is a public or private place such as a car, park, abandoned building, bus or train station, airport or campground.

Are you an English Language Learner? Yes No

Do you have limited ability in speaking, reading, writing or understanding English? Do you meet one of the following two conditions?

- Is your native language a language other than English?
- Do you live in a family or community where a language other than English is the main language?

Do you think you have a cultural barrier? Yes No

Do you have attitudes, beliefs, customs or practices that may make it hard for you to find work?

Do you lack basic skills? Yes No

Are you unable to solve problems, or read, write, or speak English at a level necessary to function on the job, in your family, or in society?

This question is voluntary: Do you, a friend, or any member of your family have a history of opioid use?

(Grant funding may be available to assist you in returning to work.) Yes No

I certify that the information given on this document is true and accurate to the best of my knowledge.

Signature

Date