



# WORKFORCE INVESTMENT AGENCY

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Applicant Name

Date

## GENERAL ELIGIBILITY REQUIREMENTS

- Proof of Age**  
*(Driver's License, Baptismal Record, Birth Certificate, DD-214, Federal, State or Local Identification Card, U.S/Foreign Passport, Public Assistance Records, School ID Card, Work Permit, Selective Service Registration, Signed Letter from a parent or guardian, Medical Records, Self-Attestation)*
- Social Security Card**  
*(Social Security Card, W-2 Form, Social Security Administration Award Letter, DD-214, Employment Records showing number, Public Assistance Records showing number)*
- Education and Training**  
*(GED Certificate, Diploma, Attendance Records, Transcripts, Drop out Letter, School Documentation, Self-Attestation)*
- Proof of Citizenship**  
*(Alien Registration Card attached with USCIS Form I-151, I-551, I-94, I-668A, I-797, I-179, Baptismal Certificate with Place of Birth, Birth Certificate, DD-214, Foreign Passport stamped Eligible to Work, Naturalization Certification, Voter Registration Card, U.S Passport, I-9/I-94)*
- 6-Month Period of Household Income (Submit ALL that apply)**  
*(Alimony Agreement, Award Letter from Veteran's Administration, Business Financial Records, Compensation Award Letter, Court Award Letter (Child Support), Employer Statement/Contract, Housing Authority Verification, Pay Stubs, Pension/Annuity Statement, Public Assistance Records, Social Security Administration Benefits, Self-Attestation)*
- Selective Service Registration \*For MALES born on or after 01/01/1960\***  
*(Contact with Selective Service (847) 688-6888, DD-214, Selective Service Acknowledgement/Verification, Selective Service Card, Selective Service Status Information Letter attached with Stamped Post Office Receipt)*
- Current Resume**

## OTHER ELIGIBILITY DETERMINATIONS

- Certification of Disability**  
*(School 504 Records provided by Student, Assessment Test Results, School Individualized Education Program (IEP) record, Self Attestation)*
- Displaced Homemaker**  
*(Intake Application, Spouse's Layoff Notice, Spouse's Death Record, Spouse's Permanent Change of Station (PCS) Orders, Divorce Records, Applicable Court Records, Copy of Bank Records (showing financial dependence on spouse, no separate individual income support, or no employment income earned), Individual Employment Plan, Self Attestation)*
- Dislocated Worker**  
*(Verification from Employer, Notice of Layoff/Termination, Self Attestation)*
- Veteran Status Information**  
*(DD-214, Letter from Veteran's Administration)*
- Low-Income (Submit ALL that apply)**  
*(NAP Eligibility Verification, NAP Disposition Form, Medicaid Card, SSI/SSDI Receipt of Benefits Verification, SSI/SSDI Eligibility Verification, Public Assistance Records/Printout)*
- School Status Information**  
*(Applicable Records from Education Institution, Self Attestation)*
- Partner Program Participation**  
*(Letter of Participation from appropriate Program)*
- WIOA Youth Services (14-24 years old)**  
**In-School Youth** *(Current STAR Math and Reading Results, Current SAT 10 Score)*  
**Out-of-School Youth** *(Most recent STAR Math and Reading Results, SAT 10 Score, CASAS Results)*



**WIOA APPLICATION FORM**

**APPLICANT INFORMATION**

**FULL LEGAL NAME:** *(Last Name, First Name, M.I.)*

**SOCIAL SECURITY NUMBER:**



**RESIDENTIAL ADDRESS:** *(Street Name & Village)*

**MAILING ADDRESS:**



**CITY:**

**STATE:**

**ZIP CODE:**

**COUNTRY:**

Saipan  Tinian  Rota

Northern Mariana Islands

United States

**PRIMARY PHONE NUMBER:**

**ALTERNATIVE PHONE NUMBER:**

**EMAIL ADDRESS:**




**EMERGENCY CONTACT:**

**ALTERNATIVE CONTACT:**

Name:

Name:

Contact Number(s):

Contact Number(s):

Relationship:

Relationship:

**DEMOGRAPHIC INFORMATION**

**DATE OF BIRTH:** *(mm/dd/yyyy)*

**AGE:**

**GENDER:**



Male  Female  I do not wish to answer

**CITIZENSHIP:**

Citizen of U.S or U.S Territory  Citizen of Freely Associated States I-9/I-94  Alien/Refugee admitted to U.S  
 U.S Permanent Resident  Other: *Please Specify:* \_\_\_\_\_

**ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES?**  Yes  No

**HAVE YOU REGISTERED FOR SELECTIVE SERVICE?** *(For MALES born on or after 01/01/1960)*  Yes  No  Not applicable

**SELECTIVE SERVICE REGISTRATION NUMBER:**

**SELECTIVE SERVICE REGISTRATION DATE:**



**ETHNICITY:** *Please select ALL that apply*

- African American/Black  American Indian/Alaskan Native  White  
 Asian:  Bangladesh  Bhutanese  Cambodian  Chinese  Filipino  Indian  Japanese  Malaysian  Nepalese  
 Pakistani  Sikkimese  Sri Lankan  Thai  Vietnamese  
 Hawaiian/Other Pacific Islander:  Carolinian  Chamorro  Chuukese  Guamanian  Kosraean  Marshallese  Micronesian  
 Palauan  Pohnpeian  Yapese

**EDUCATION INFORMATION**

- I do not have a High School Diploma/Equivalency. Last grade completed was \_\_\_\_\_ grade.  Vocational School Certificate  
 Certificate of Attendance/Completion (Disabled Individuals)  Associate's Degree  
 High School Diploma/Equivalent  Bachelor's Degree  
 1 year at College or Technical or Vocational School  Master's Degree  
 2 years at College or Technical or Vocational School  Doctorate's Degree  
 3 years at College or Technical or Vocational School  Specialized Degree (e.g. MD, DDS)

**ARE YOU CURRENTLY ATTENDING SCHOOL?**  Yes, High School, Junior High, or Elementary School  Yes, College, Technical or Vocational School  No, Not attending any School

**DISABILITY INFORMATION**

**DO YOU CONSIDER YOURSELF TO HAVE A DISABILITY?**  Yes  No  I do not wish to disclose

**IF YES, CATEGORY OF DISABILITY:**

- Physical/Chronic Health Condition  Physical/Mobility Impairment  Mental/Psychiatric Disability  Vision-related Disability  
 Hearing-related Disability  Learning Disability  Intellectual Disability  I do not wish to disclose

HAVE YOU RECEIVED SERVICES FROM VOCATIONAL REHABILITATION?  Yes  No  I do not wish to disclose

**SPOUSE OR CAREGIVER OF A MILITARY MEMBER INFORMATION**

ARE YOU THE SPOUSE OF A MEMBER OF THE ARMED FORCES WHO IS ON ACTIVE DUTY?  Yes  No

ARE YOU A SPOUSE OR FAMILY CAREGIVER TO A MEMBER OF THE ARMED FORCES WHO IS WOUNDED, ILL, INJURED AND RECEIVING TREATMENT IN A MILITARY FACILITY OR WARRIOR TRANSITION UNIT?  Yes  No

ARE YOU THE SPOUSE OF SOMEONE IN THE ACTIVE DUTY MILITARY SERVICE, NATIONAL GUARD OR RESERVES WHO IS CURRENTLY ACTIVATED?  Yes  No

ARE YOU THE SPOUSE OF A VETERAN WHO HAS A PERMANENT, TOTAL SERVICE CONNECTED DISABILITY OR HAD THE DISABILITY AT THE TIME OF DEATH, OR DIED WHILE THE DISABILITY WAS IN EXISTENCE?  Yes  No

OR  
A SPOUSE OF A SERVICE MEMBER ON ACTIVE DUTY WHO DIED OR HAS BEEN MISSING IN ACTION (MIA), CAPTURED IN THE LINE OF DUTY OR FORCIBLY DETAINED FOR A TOTAL OF MORE THAN 90 DAYS?  Yes  No

**VETERAN INFORMATION**

ARE YOU CURRENTLY IN THE U.S MILITARY OR A VETERAN?  Yes  No (IF NO, PROCEED TO EMPLOYMENT INFORMATION)

ARE YOU WITHIN 24 MONTHS OF RETIREMENT OR 12 MONTHS OF DISCHARGE FROM THE MILITARY (TRANSITIONING SERVICE MEMBER)?  Yes  No

MOST RECENT ACTIVE DUTY BEGIN DATE: \_\_\_\_\_

MOST RECENT ACTIVE DUTY END DATE: \_\_\_\_\_

DO YOU HAVE PRIOR SERVICE DATES?  Yes  No

DISABLED VETERAN:  Yes, <= 180 days  Yes, eligible Veteran  Yes, other eligible person  No

HAVE YOU RECEIVED SERVICES FROM VETERANS VOCATIONAL REHABILITATION (CHAPTER 31):  Yes  No  Unknown

ARE YOU A HOMELESS VETERAN?  Yes  No

VETERAN STATUS:  Yes, <= 180 days  Yes, eligible Veteran  Yes, other eligible person  No

**EMPLOYMENT INFORMATION**

**CURRENT EMPLOYMENT STATUS:**

- Employed:  Full-Time  Part-Time
- Employed, but received notice of termination of employment or military separation
- Not employed
- Never worked

**TYPE OF BUSINESS WORKED IN:**

- Private business
- Local government
- Federal government
- Non-profit organization
- Higher education
- State government
- Education (K-12)
- Other:

IF YOU ARE CURRENTLY UNEMPLOYED, WHEN WAS YOUR LAST EMPLOYMENT? (mm/dd/yyyy) \_\_\_\_\_

ARE YOU UNEMPLOYED DUE TO LAYOFF OR TERMINATION?  Yes  No  Not Applicable

DO YOU HAVE A RESUME?  Yes  No IF YES, WAS ONE PROVIDED?  Yes  No

**EMPLOYMENT HISTORY:**

Company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job title: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start date (mm/dd/yyyy): \_\_\_\_\_ End date (mm/dd/yyyy): \_\_\_\_\_

Reason for leaving:  Laid off  Quit  Terminated  Other employment  Temporary/Contract ended  Other

Explain reason: \_\_\_\_\_

Company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job title: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start date (mm/dd/yyyy): \_\_\_\_\_ End date (mm/dd/yyyy): \_\_\_\_\_

Reason for leaving:  Laid off  Quit  Terminated  Other employment  Temporary/Contract ended  Other

Explain reason: \_\_\_\_\_

Company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job title: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start date (mm/dd/yyyy): \_\_\_\_\_ End date (mm/dd/yyyy): \_\_\_\_\_

Reason for leaving:  Laid off  Quit  Terminated  Other employment  Temporary/Contract ended  Other

Explain reason: \_\_\_\_\_

## DISPLACED HOMEMAKER/DISLOCATED WORKER INFORMATION

WITHIN THE LAST 12 MONTHS, HAVE YOU RECEIVED A NOTICE OF TERMINATION OR LAYOFF FROM YOUR JOB OR RECEIVED DOCUMENTATION THAT YOU ARE SEPARATING FROM MILITARY SERVICE?  Yes  No

IF YES, LAYOFF/SEPARATION DATE: \_\_\_\_\_ DISLOCATION EMPLOYER: \_\_\_\_\_

DISLOCATION EMPLOYER ADDRESS: \_\_\_\_\_ DISLOCATION HOURLY RATE: \_\_\_\_\_

WERE YOU DEPENDENT ON THE INCOME OF A FAMILY MEMBER, SPOUSE, OR SIGNIFICANT OTHER OR PROVIDING UNPAID SERVICES, BUT NO LONGER SUPPORTED BY THAT INCOME DUE TO: *Please select ALL that apply*

Divorce/Separation  Death  Incarceration  Relocation  Other: \_\_\_\_\_  Not applicable

WERE YOU SELF-EMPLOYED AS A FARMER, RANCHER, FISHERMAN, ETC?  Yes  No

## PUBLIC ASSISTANCE AND PARTNER SERVICES INFORMATION

WITHIN THE LAST SIX MONTHS, DID YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE ASSISTANCE FROM ANY OF THE FOLLOWING:

Childcare Assistance (DCCA-CCDF)  Housing Assistance  Karidat  
 DCCA-Nutrition Assistance Program (NAP)  Supplemental Security Income (SSI)  WIOA Title I Program  
 Medicaid Program  Social Security Disability Insurance (SSDI)

ARE YOU RECEIVING SERVICES FROM ANY OF THE FOLLOWING PARTNER PROGRAM SERVICES?

Adult Basic Education  Substance Abuse, Addiction, and Rehabilitation  DOL-Employment Services  
 Office of Vocational Rehabilitation  CGC-Transitional Living Center  Veterans Administration Benefits  
 Northern Marianas Technical Institute  Office of Adult Probation  
 CNMI Drug Court  DCCA-Division of Youth Services

## INDIVIDUAL BARRIERS INFORMATION

ARE YOU A SINGLE PARENT?  Yes  No

HAVE YOU BEEN CONVICTED OF A CRIME?  Yes  No

ARE YOU HOMELESS?  Yes  No

DO YOU SPEAK, READ AND UNDERSTAND ENGLISH?  Yes  No

## ADDITIONAL INFORMATION

HOW DID YOU HEAR ABOUT US?

Website  Job Fair  Social Media  
 Business Colleague  Job Center  Other: \_\_\_\_\_  
 Family/Friends  Advertisements

WHAT ARE YOUR OCCUPATIONAL GOALS?

1.

2.

3.

**RELEASE OF INFORMATION CONSENT/CERTIFICATION AND ACKNOWLEDGEMENT**

**APPLICANT NAME:**

**RELEASE OF INFORMATION**

**INITIAL**

I agree to allow the CNMI Department of Labor-Workforce Investment Agency Division to share the above information and other relevant information to other agencies for the purpose of assisting me in obtaining my educational, training and/or employment goal as well as obtain support services that may be available.

\_\_\_\_\_

**RELEASE OF INFORMATION FOR EDUCATION INSTITUTIONS**

**INITIAL**

I authorize the release of my current and past educational records from high schools, colleges, universities, and training schools to the CNMI Department of Labor-Workforce Investment Agency Division. Such records include my current/past enrolment(s), transcripts, attendance records, graduation/completion information and diploma/certificate(s)/credential(s) attained. I understand that under the Family Educational Rights and Privacy Act of 1974 (FERPA), which is a Federal Law that protects the privacy of student education records that the staff of DOL-WIA Division must have my written consent to obtain my educational records. I certify that this authorization of release form may be sent as fax, email or a photo copy presented in person with appropriate identification from the above agency's staff to record holder.

\_\_\_\_\_

**RELEASE OF INFORMATION FOR EMPLOYMENT**

**INITIAL**

I authorize the release of my current and past employment information to the CNMI Department of Labor-Workforce Investment Agency Division without liability, any information in their possession relevant to my current or past employment. Such records include information related to my job title, start/end date, hourly wages, hours worked per week, and performance.

\_\_\_\_\_

**CERTIFICATION AND ACKNOWLEDGEMENT**

**INITIAL**

I certify that the information provided is true, complete, and correct to the best of my knowledge. I understand that my willful misstatement of the facts may cause my forfeiture of rights in the WIOA Program and may result in criminal actions. I give my permission for outside sources to be contacted and for them to disclose any information necessary to verify my eligibility for WIOA Title I Programs and Services. I further understand and agree that my social security number and other information on this application will be provided to other government agencies if required by law or necessary for participation.

\_\_\_\_\_

**PLEASE READ CAREFULLY BEFORE SIGNING**

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent of Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

DOL-WIA Staff Signature \_\_\_\_\_

Date: \_\_\_\_\_

**FAMILY SIZE AND HOUSEHOLD INCOME AND ADDRESS VERIFICATION**

I, \_\_\_\_\_ currently reside at \_\_\_\_\_  
*Applicant Name* *Street name and Village*

\_\_\_\_\_ with the following household members:  
*City* *State* *Zip Code*

<u>NAME OF HOUSEHOLD MEMBER</u>	<u>RELATIONSHIP TO APPLICANT</u>	<u>SOURCE OF INCOME IN THE LAST 6 MONTHS</u>
1. _____	<b>Self</b>	<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
2. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
3. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
4. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
5. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None

**NOTE: FOR HOUSEHOLDS OF MORE THAN 5, PLEASE USE THE BACK SIDE OF THIS PAGE OR A SEPARATE SHEET FOR ADDITIONAL HOUSEHOLD MEMBERS.**

**PLEASE READ CAREFULLY BEFORE SIGNING**

I certify that the information provided is true, complete, and correct to the best of my knowledge. I understand that falsification of data is a crime and is subject for immediate termination from CNMI DOL-WIA Division Title I Programs and Services and any monies paid to or on behalf of the participant will require repayment.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Received by: \_\_\_\_\_  
*DOL-WIA Staff Print and Sign*

Household Size: \_\_\_\_\_ 6 Month Income: \_\_\_\_\_

Certified by: \_\_\_\_\_  
*DOL-WIA Staff Print, Sign and Date*

**STAFF NOTES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

