Chautauqua Works
UNIVERSAL INTAKE FORM

Workforce New York
Put us to work for you

____ Adult ____DW _____WTW **Intake Date: _____ / _____ / _____**
Specialist: _____

Name: _____ **Soc. Sec. #** __ __ __ - __ __ - __ __ __ __
Last, First, Middle Initial

Date of Birth:_____

Address:

_____
No., Street, Apt. #, P.O. Box City/Town Zip Code County

Phone Number:_____ **Alt. Phone Number**: _____

Veteran: ____ NO _____YES ____ Less than 180 Days of Active Service ____ Recently Separated: Date: _____
Honorable Conditions? Yes ____ No _____
_____ Vietnam Era Vet ____ Vietnam Combat/Theater ____ Armed Forces Expedition Medal
_____ Persian Gulf Era ____ Persian Gulf Theater ____ Other Combat Theater
_____ Disabled >30% (What % ____) ____ Iraq ____ Disabled <30% (What %____)

Education: Highest Grade Completed _____ (1-16+) Current Student? ○Yes ○No Where: _____
○High School Graduate ○Full Time ○Part Time Major: _____
○GED ○Vocational / Technical Training Last School Attended? _____
College (highest level): ○Associate's Degree ○Bachelor's Degree ○Post Bachelor's Degree Major: _____
Certificate(s)/Licenses: ○_____○Other: _____

TO BE COMPLETED BY YOU AND YOUR SPECIALIST *(may be helpful when seeking assistance for you):*
_____ preparing for non-traditional training/employment _____ single parent _____ **disability (physical learning)**
_____ do you currently receive: SSI TANF FS _____ 200% _____ displaced homemaker _____ limited English
_____ convicted of a felony Other barriers to employment: _____

Are you a United States Citizen? ____Yes ____No
If No, Are your legal to work in the US? ___Yes ___No Alien ID # _____ Exp._____

Employment:
Are you presently employed? ○ Yes ○ No Have you earned any wages in the last 7 consecutive days? ○ Yes ○ No

List Current/Previous Employer- _____
Address (No., City, State, Zip): _____
Job Title: _____ Duties: _____
Reason for Leaving: _____
Dates Employed: From: _____ / _____ / _____ To: _____ / _____ / _____ Hourly Wage: $ _____
# of hours per week: _____

Previous Employer-_____
Address (No., City, State, Zip): _____
Job Title: _____ Duties: _____
Reason for Leaving: _____
Dates Employed: From: _____ / _____ / _____ To: _____ / _____ / _____ Hourly Wage: $ _____
# of hours per week: _____

Previous Employer-_____
Address (No., City, State, Zip): _____
Job Title: _____ Duties: _____
Reason for Leaving: _____
Dates Employed: From: _____ / _____ / _____ To: _____ / _____ / _____ Hourly Wage: $ _____
# of hours per week: _____

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

The purpose of the Authorization Form is to enable agencies identified as members of the ***chautauqua WORKS*** Consortium to better serve you and/or your child(ren) through coordinated service planning and delivery. Representatives of these agencies may share information in order to arrange for appropriate and prompt delivery of services as planned.

Is there any Agency that you do not want us to share your information with?

Yes ____ No ____

If Yes, please list the name(s) of the agency/agencies below:

_____
_____
_____
_____

The information that will be shared among participating ***chautauqua WORKS*** consortium will make it possible to coordinate the services you and/or your child(ren) receive. Check below the information you want to be shared.

- ☐ Customer Information
- ☐ Employment Background and Information
- ☐ Eligibility
- ☐ Previous Workforce Prep. Services
- ☐ Other: _____
- ☐ Education/Training/Skills Background
- ☐ Support Service Information
- ☐ Educational./Vocational Assessment Information
- ☐ Unemployment Insurance
- ☐ Other: _____

I understand and have had explained to me that this release authorizes an exchange of information between Service Agency members in order to provide me and/or my child(ren) with the most complete and thorough services available. It does not allow the release of HIV-related information, drug and alcohol records, or mental health reports. It does not authorize release to any other person or agency except those agencies which are partnership members' of ***chautauqua WORKS***. Unless revoked in writing, this release and exchange shall remain in force for a period of 12 months from the date or authorization. My signature below indicates that I have been informed of and understand the eligibility information provided within this form and certify that it is true and correct and subject to verification. I understand I will have to provide specific documentation as requested by my workforce development specialist to be eligible for any financial assistance and if I do not comply I shall be personally liable for all costs incurred. I understand that falsification is grounds for termination and may result in action to recover any monies paid to me while participating in the program.

_____	_____
Signature of Participant	Signature of Parent/Guardian (When Required)
_____	_____
Date	Date
_____	_____
Print Name	Print Name
_____	_____
Eligibility Interviewer/Specialist	Registration Date

Acknowledgement of Receipt of Notice of Rights

I have read this form and understand that I have a right to file a grievance or a discrimination complaint if I feel that my rights were violated by Chautauqua Works or in connection with a WIA Title I financially assisted program or activity.

I acknowledge receipt of the formal Grievance/Complaint/Reasonable Accommodations policies in addition to this Notice of Rights.

Signature: _____

Date: _____