APPLICATION FOR PROGRAM PARTICIPATION

HealthQuest Apprenticeship
Learn. Serve. Succeed.

APPLICANT INFORMATION	
Name:	Application Date:
Address:	County:
City, State:	Zip Code:
Phone:	Alternate Phone:
Date of Birth:	Email:
SSN:	
Emergency Contact:	Emergency Contact Phone:

DEMOGRAPHIC INFORMATION

Sex: ☐ Male ☐ Female

Are you Hispanic / Latino? ☐ Yes ☐ No

Citizenship:

☐ United States citizen
☐ Lawfully permanent resident
☐ Other immigrant authorized to work in the U.S.

Race:

☐ American Indian / Alaska Native
☐ Asian
☐ Black / African American
☐ Native Hawaiian / Other Pacific Islander
☐ White / Caucasian

Do you consider yourself to have a disability? ☐ Yes ☐ No
Are you an ex-offender (a person who has been subject to any stage of the criminal justice process)? ☐ Yes ☐ No
Do you require assistance in overcoming barriers to employment resulting from a record of arrest or conviction? ☐ Yes ☐ No

Do you have limited ability in speaking, reading, writing, or understanding the English language because: (a) your native language is a language other than English, or (b) you live in a family or community where a language other than English is the dominant language? ☐ Yes ☐ No
If yes, please list your native or dominant language: _____

FAMILY and INCOME INFORMATION

Number of family members in household: _____

Your annual income: $_____

Total annual household income: *Include income from all sources before taxes and deductions. Please include income from yourself as well as all members of your household.*

$_____

Do you receive (or have you received in the prior 6 months) any of the following assistance? (check all that apply)
☐ SSI or SSDI ☐ Temporary Assistance for Needy Families (TANF) ☐ Refugee Assistance
☐ SNAP (food stamps) ☐ Reemployment (Unemployment) Assistance - If yes, how many weeks? _____
☐ Other: _____

EDUCATION INFORMATION

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Do you have a high school diploma? ☐ Yes ☐ No • If no, highest grade completed (1 – 12)? _____ • If no, do you have a GED? ☐ Yes Date Earned: _____ ☐ No Did you receive a certificate of attendance / completion as a result of having a disability and successfully completing an Individualized Education Program (IEP)? ☐ Yes ☐ No	Are you currently enrolled in an educational program? ☐ Yes ☐ No If **currently** enrolled in an educational program: Name of School: _____ Program of Study: _____ Anticipated Date of Completion: _____
Highest grade level achieved (check one): ☐ Less than High School (HS) ☐ HS Diploma or GED ☐ 1 or more years of postsecondary education (e.g. some college courses) ☐ Vocational / Technical Certificate ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate Degree Major(s): _____	List any certifications and/or licenses achieved, including dates, below: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

VETERAN STATUS

Have you served in the U.S. Military? ☐ Yes, eligible veteran ☐ Yes, less than or equal to 180 days and was discharged under other than honorable conditions. ☐ No	Are you the spouse of a military veteran? ☐ Yes ☐ No

I hereby certify, to the best of my knowledge, the above information is true. I understand the information is subject to verification and agree to provide such documentation as required. This project was funded by a grant awarded under the H-1B grants, as implemented by the U.S. Department of Labor's Employment and Training Administration. The collection of this information helps to track the long-term success of this training program. Your personal information is kept confidential and secure and will not be shared with any outside agencies other than those involved with the support or oversight of the H-1B grant. Your information will never be sold or shared with third party agencies through your participation in grant supported training activities.

In addition to requesting a range of information from project participants, including demographic information, the use of your Social Security Number is also requested in order to access wage and employment information through state databases. Although you cannot be denied service for failure to provide your Social Security Number, we strongly encourage you to do so in order to enable the project to quantify specific employment-related outcomes. Your personal information will be kept confidential.

X: _____ _____

Applicant Signature Date

X: _____ _____

Parent/Guardian Signature Date

(Required for applicants under the age of 18)

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Self-Attestation: Employment Status

Applicant Name: _____

Check the box(es) below that best describes your current employment status. Please also attach a copy of your current resume.

- ☐ **Unemployed -** I hereby certify that I am without a job, seeking employment, and available to work.

- ☐ **Long-Term Unemployed**: I have been unemployed for 27 consecutive weeks or longer.

- ☐ **Employed - I certify that I am (check all that apply):**
  - ☐ Employed part-time and seeking full-time or long-term work.
  - ☐ Employed in a temporary or seasonal position that is anticipated to end.
  - ☐ Employed, but I have received a notice of layoff, termination, or military separation is pending.
  - ☐ Employed, but not currently connected to a full-time job commensurate with my level of education, skills, or wages I have previously earned.
  - ☐ Employed, or self-employed, but I would like to transition my employment to a new job or occupation.
  - ☐ Employed, but in need of additional training to upgrade my skills to retain my position or advance into a new position with my current employer.

- ☐ **None of the statements above apply to me** (describe your current employment status):_____

  _____

  _____

  _____

I hereby certify, to the best of my knowledge, the above information is true. I understand the information is subject to verification and agree to provide such documentation if required.

X: _____
Applicant Signature

X: _____
Parent/Guardian Signature
(Required for participants under the age of 18)

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Records Release Consent Form

Name: _____

As a participant of the *HealthQuest Apprenticeship* (HQA) program, I hereby authorize the release of confidential information to its employees, representatives or agents. The representatives of *HealthQuest Apprenticeship* are authorized by me to obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions. This information may include, but is not limited to, educational records (such as testing scores, attendance information, etc.), public assistance records and income/employment information.

I hereby give consent for *HealthQuest Apprenticeship* program staff to engage in verbal, written, facsimile or computerized communication of information required to verify my eligibility for services, identify services or agencies to assist me, assess my qualifications to enter the program, monitor progress while participating in the program, to provide employment/educational recommendations, and follow-up completion of training.

I hereby waive any and all rights and claims I may have to privacy regarding the employer, its agents, employees or representatives for seeking, gathering and using such information in the verification process and all other persons, corporations or organizations, be it Federal, State or Local, for furnishing such information about me.

I further understand that this release will be effective during the length of my participation in order to assist staff with their follow-up procedures.

X: _____ _____

Participant Signature Date

X: _____ _____

Parent/Guardian Signature Date

(Required for participants under the age of 18)

Media Release Form

The *HealthQuest Apprenticeship* (HQA) program requests your permission to share your experiences while participating in or receiving a benefit from the program. With your permission, there is a possibility that you may be photographed, videoed, have your voice recorded or comments printed for the purpose of promoting the program. Your authorization below allows the *HealthQuest Apprenticeship* program, its agents, contracted service providers and their respective staff, the broadcast media or other persons authorized to photograph, videotape, audiotape or print your comments.

Your participation is voluntary and will take place during scheduled hours of a program, event or at a time that is convenient to you and the organization. If you do not agree, you will not be photographed, videoed, have your voice recorded or your comments printed during a program or event. Your eligibility or participation in the *HealthQuest Apprenticeship* program will not be affected by your decision.

- ☐ Yes, I give permission for the *HealthQuest Apprenticeship* program, its agents, contracted service providers and their respective staff, broadcast or print media to photograph, video record, audio record or print comments from me. I understand that I will not receive any form of compensation for the use of my picture, voice, or comments. Any photographs, video, or audio of me or comments from me are and will remain the property of the *HealthQuest Apprenticeship* program.
- ☐ No, I do not give my permission for the *HealthQuest Apprenticeship* program, its agents, contracted service providers and their respective staff, broadcast or print media to photograph, video record, audio record or print comments from me.

I understand that I may revoke my permission at any time by notifying the *HealthQuest Apprenticeship* program in writing of my decision to do so.

X: _____

Participant Signature Date

X: _____

Parent/Guardian Signature Date

(Required for participants under the age of 18)

Grievance and Complaint Form

As an applicant, participant, or customer of HealthQuest Apprenticeship, if you feel that your rights are being violated due to an act of discrimination based on race, color, religion, sex (including pregnancy, childbirth, or other related medical conditions; transgender status; or gender identity), national origin (including limited English proficiency), marital status, age, disability, political affiliation or belief, or citizenship/status as a lawfully admitted immigrant authorized to work in the United States, you may file a complaint **within 180 days of the alleged violation** directly with any of the agencies listed below:

Florida Alcohol and Drug Abuse Association (FADAA) (local agency)	**U.S. Department of Labor Civil Rights Center (CRC)**
Send by postal mail: FADAA <Name, Title> 2868 Mahan Drive, Suite 1 Tallahassee, FL 32308-5469 **Email**: <email?>	**Send by postal mail**: Director Civil Rights Center (CRC) Attention: Office of External Enforcement U.S. Department of Labor 200 Constitution Avenue, NW Room N–4123 Washington, DC 20210 **Fax**: (202)693-6505, ATTN: Office of External Enforcement (limit of 15 pages) **Email:** CRCExternalComplaints@dol.gov

If you have a problem that arose in connection with the program operated in your area, you should take the following steps: 1) Discuss the matter with the staff member directly. If the problem is not resolved to your satisfaction, ask to speak with their supervisor. 2) If, after discussion with the supervisor, the issue is still not resolved to your satisfaction, you will be given information about the process to file a formal written grievance/complaint and to request a hearing on the issue. You may file a complaint with either the local agency and/or the Department of Labor's Civil Rights Center. Regardless of where they are filed, all complaints must be filed in writing, and must include the following information:

1. The name of and contact information for the complainant
2. The name of and contact information for the recipient that committed the alleged discriminatory act(s)
3. A description of the alleged discriminatory act(s) in sufficient detail to allow a reader to understand what act(s) occurred, when the act(s) occurred, and what the alleged basis of (reason for) the discrimination (e.g., race, age, national origin)
4. The signature of the complainant, or the signature of the complainant's authorized representative (if any)

Upon receipt of the written grievance/complaint by the local agency, you will be notified of the hearing date, and a final decision will be issued via a written Notice of Final Action. An appeal may be filed at either the local or the federal level if a) the decision is not completed **within 90 days**, or b) either party is dissatisfied with the decision.

If you are dissatisfied with the resolution of your complaint at the local agency, then you may file a new complaint with CRC **within 30 days** of the date on which you receive the Notice of Final Action. If the local agency fails to issue the Notice within 90 days of the date on which the complaint was filed, you may file a new complaint with CRC **within 30 days of the expiration** of the 90-day period (in other words, **within 120 days** of the date on which the original complaint was filed).

An initial complaint filed directly with CRC must be filed within 180 days of the alleged discrimination. CRC may extend the filing time for good cause. To file a complaint directly with CRC, you must complete CRC's Complaint Information Form (CIF) and Privacy Act Consent Form. CRC will not process a complaint without these forms. Complaints and Privacy Act Consent Forms may be submitted to CRC in one of the ways listed in the table above.

You have the right to be represented in the complaint process by an attorney or other representative. Written notice from the complainant must be provided identifying the representative. A recipient is prohibited by law from retaliating against any person who has filed a complaint, testified, or participated in a manner in an investigation or other equal opportunity proceeding.

As a participant enrolled with HealthQuest Apprenticeship, I certify that I have read the above statement and understand my rights and responsibilities as enumerated in the statement.

X_____ _____
Participant Signature Date

X_____ _____
Parent Signature (if under age 18) Date