

# APPLICATION FOR PROGRAM PARTICIPATION



APPLICANT INFORMATION	
Name:	Application Date: Hire Date:
Address:	County:
City, State:	Zip Code:
Phone:	Alternate Phone:
Date of Birth:	Email:
SSN:	Employer name: Current Career Title:
Emergency Contact:	Emergency Contact Phone:
DEMOGRAPHIC INFORMATION	
<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female Are you Hispanic / Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Citizenship:</b> <input type="checkbox"/> United States citizen <input type="checkbox"/> Lawfully permanent resident <input type="checkbox"/> Other immigrant authorized to work in the U.S.	<b>Race:</b> <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White / Caucasian
Do you consider yourself to have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you an ex-offender (a person who has been subject to any stage of the criminal justice process)? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you require assistance in overcoming barriers to employment resulting from a record of arrest or conviction? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list your native or dominant language: _____	
FAMILY and INCOME INFORMATION	
Number of family members in household: _____	Your annual income: \$ _____
<b>Total annual household income:</b> <i>Include income from all sources before taxes and deductions. Please include income from yourself as well as all members of your household.</i> \$ _____	
Do you receive (or have you received in the prior 6 months) any of the following assistance? (check all that apply) <input type="checkbox"/> SSI or SSDI <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) <input type="checkbox"/> Refugee Assistance <input type="checkbox"/> SNAP (food stamps) <input type="checkbox"/> Reemployment (Unemployment) Assistance - If yes, how many weeks? _____ <input type="checkbox"/> Other: _____	
EDUCATION INFORMATION	

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<p>Do you have a high school diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• If no, highest grade completed (1 – 12)? _____</li> <li>• If no, do you have a GED?  <input type="checkbox"/> Yes Date Earned: _____ <input type="checkbox"/> No</li> </ul> <p>Did you receive a certificate of attendance / completion as a result of having a disability and successfully completing an Individualized Education Program (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Are you currently enrolled in an educational program?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>currently</b> enrolled in an educational program:          Name of School: _____          Program of Study: _____          Anticipated Date of Completion: _____</p>
<p>Highest grade level achieved (check one):</p> <p><input type="checkbox"/> Less than High School (HS)</p> <p><input type="checkbox"/> HS Diploma or GED</p> <p><input type="checkbox"/> 1 or more years of postsecondary education (e.g. some college courses)</p> <p><input type="checkbox"/> Vocational / Technical Certificate</p> <p><input type="checkbox"/> Associate's Degree</p> <p><input type="checkbox"/> Bachelor's Degree</p> <p><input type="checkbox"/> Master's Degree</p> <p><input type="checkbox"/> Doctorate Degree</p> <p>Major(s): _____</p>	<p>List any certifications and/or licenses achieved, including dates, below:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
<b>VETERAN STATUS</b>	
<p>Have you served in the U.S. Military?</p> <p><input type="checkbox"/> Yes, eligible veteran</p> <p><input type="checkbox"/> Yes, less than or equal to 180 days and was discharged under other than honorable conditions.</p> <p><input type="checkbox"/> No</p>	<p>Are you the spouse of a military veteran?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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  
 (Required for applicants under the age of 18)

\_\_\_\_\_  
 Date

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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)

# APPLICATION FOR PROGRAM PARTICIPATION



## 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  
(Required for participants under the age of 18)

\_\_\_\_\_  
Date

# APPLICATION FOR PROGRAM PARTICIPATION



## 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:

<b>Florida Alcohol and Drug Abuse Association (FADAA) (local agency)</b>	<b>U.S. Department of Labor Civil Rights Center (CRC)</b>
<p><b>Send by postal mail:</b> FADAA <b>Christina Brown</b> 2868 Mahan Drive, Suite 1 Tallahassee, FL 32308-5469</p> <p><b>Email:</b> <a href="mailto:Chris@floridabha.org">Chris@floridabha.org</a></p>	<p><b>Send by postal mail:</b> 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 <b>Fax:</b> (202)693-6505, <b>ATTN:</b> Office of External Enforcement (limit of 15 pages) <b>Email:</b> <a href="mailto:CRCEXternalComplaints@dol.gov">CRCEXternalComplaints@dol.gov</a></p>

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.

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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

**PARTICIPANT ELIGIBILITY CHECKLIST**

<b>PARTICIPANT NAME:</b>		<b>LAST 4 DIGITS OF SSN:</b>
<b>APPLICATION DATE:</b>		
<b>GENERAL ELIGIBILITY DOCUMENTATION</b>		
Applicant must meet the general eligibility requirements and furnish evidence for each criterion. For each eligibility category select one document to verify eligibility. Copies of the documentation must be present in the case file.		
<b>SOCIAL SECURITY NUMBER</b>		<b>Date and initial:</b>
<input type="checkbox"/> Social Security Card <input type="checkbox"/> Social Security Benefits Statement <input type="checkbox"/> DD-214, Report of Transfer or Discharge <input type="checkbox"/> Employment Record or Paystub <input type="checkbox"/> IRS Form Letter		<input type="checkbox"/> Letter from Social Security Administration <input type="checkbox"/> School Records <input type="checkbox"/> W-2 Form <input type="checkbox"/> Other forms of ID if SSN number is present Specify: _____
<b>CITIZENSHIP / AUTHORIZATION TO WORK</b>		<b>Date and initial:</b>
<input checked="" type="checkbox"/> Documentation specified on the I-9 Form <input type="checkbox"/> Birth Certificate <input type="checkbox"/> U.S. Passport <input type="checkbox"/> Food Stamp Record <input type="checkbox"/> Permanent Resident Card <input type="checkbox"/> Naturalization Certification <input type="checkbox"/> Hospital Record		<input type="checkbox"/> Public Assistance Records (If place of birth is shown) <input type="checkbox"/> Baptismal Record <input type="checkbox"/> Social Security Card stamped "Work Eligible" with picture ID <input type="checkbox"/> Native American Tribal Document <input type="checkbox"/> Alien Registration Card Indicating Right to Work <input type="checkbox"/> I-766 Employment Authorization Document <input type="checkbox"/> Foreign Passport with I-551 stamp <input type="checkbox"/> Other (specify): _____
<b>AGE / IDENTITY</b>		<b>Date and initial:</b>
<input checked="" type="checkbox"/> Driver's License <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Baptismal Record <input type="checkbox"/> Hospital Record of Birth <input type="checkbox"/> Passport		<input type="checkbox"/> Public Assistance/Social Service Records <input type="checkbox"/> Work Permit <input type="checkbox"/> Native American Tribal Document <input type="checkbox"/> Federal, State or Local Government ID Card <input type="checkbox"/> DD-214, Report of Transfer or Discharge
<b>EMPLOYMENT STATUS</b>		<b>Date and initial:</b>
<b>Check one:</b> <input type="checkbox"/> Unemployed <input type="checkbox"/> Underemployed <input type="checkbox"/> Incumbent Worker <input type="checkbox"/> Employed Worker		
<input type="checkbox"/> Unemployment System Printout <input type="checkbox"/> Unemployment Paycheck <input type="checkbox"/> UI Wage Report <input type="checkbox"/> Layoff/Separation notice		<input checked="" type="checkbox"/> Pay Stub or Direct Deposit <input type="checkbox"/> Applicant Statement (Signed Self-Attestation) <input type="checkbox"/> Employer Statement (incumbent worker requires training to retain or advance employment) <input type="checkbox"/> Other (specify): _____
<b>VETERAN PRIORITY (when applicable)</b>		<b>Date and initial:</b>
<input type="checkbox"/> DD-214, Report of Transfer or Discharge <input type="checkbox"/> Cross-match with veterans data base		<input type="checkbox"/> Veterans Administration Letter/Records <input type="checkbox"/> Verification from Local Veterans Employment Representative (LVER) or Disabled Veterans Outreach Program (DVOP) <input type="checkbox"/> Other (specify): _____

Health Quest Apprenticeship Participant Eligibility – I attest that all documents used to confirm program eligibility were reviewed, verified, and copies are maintained in the participant's file.

X: \_\_\_\_\_  
 Staff Representative Signature

\_\_\_\_\_  
 Date of Eligibility Determination

\_\_\_\_\_  
 Print Staff Name





## Journeyworker Requirements and Agreement

### Definition

Department of Labor defines a JourneyWorker (JW) as a person who has worked the number of years required by established industry practices for the occupation. Use of the term may also refer to a mentor, technician, specialist, or other skilled worker who has documented sufficient skills and knowledge of an occupation through practical on-the-job experience and formal training. 6A-23.002(17) FAC

### Supervision

Journeyworker (JW) may be assigned a maximum of 3 apprentices at one time.

No Apprentice shall work without adequate or proper supervision of a fully qualified JW. Adequate supervision means the JW knows what the Apprentice is working on, is readily available, and is making sure the Apprentice has the necessary instruction and guidance to perform tasks safely, correctly, and efficiently.

### Journeyworker (JW) Qualifications

While the DOL does not specify JW credential requirements, it is important to note that the FCB requires the JW to hold one of the following credentials in the Apprentice's occupation:

- Addiction Coordinator
  - A Physician or Physician's Assistant licensed under Chapters 458 or 459, F.S.
  - A professional licensed under Chapters 490 or 491, F.S.
  - An Advanced Registered Nurse Practitioner licensed meeting ARNP designation
  - A MCAP, CAP
  - A CAC or supervisor working in collaboration with any of above licensee to oversee work performance
  
- Behavior Health Technician
  - Any of Addiction Counselor credentials
  - Individual in a supervisory position who holds a minimum of a bachelor's degree in any field.
  - A CBHT working in collaboration with any above certified/licensee to oversee work process performance
  
- Peer Specialist

Immediate supervisor or any other agency supervisors, trainers, mentors, quality assurance staff, and any other agency management or leadership staff assigned by the employer to provide supervision

### Responsibilities

- Train, observe, assign, and oversee tasks or courses in the defined apprenticeship domains
- Update Apprentice Coordinator with progress, training concerns, or potential barriers as needed
- Retain and produce evidence of all training hours, upon request
- Meet with apprentice regularly to review logs, approve, and submit progress by the last workday monthly
- Upon fulfillment of the time requirement and mastery by the Apprentice, the JW will review, complete, and submit the following to the Apprentice Coordinator using subject Format *Grad\_Apprentice name* :
  1. Work Process Schedules for each domain
  2. RTI logs for each domain with all completed courses clearly documented
  3. RTI evidence proceeding the related RTI domain log (ie: transcript, certificates)
  4. Completed Monthly Progress Report



By signing the document, the Journeyworker certifies eligibility and commitment to requirements of apprenticeship and their assigned apprentices, (*Apprentice names*)

1) \_\_\_\_\_

2) \_\_\_\_\_, and 3) \_\_\_\_\_.

-----  
**Journeyworker's Printed Name**

-----  
**Signature**

-----  
**Phone Number**

-----  
**Email Address**