

Health Careers for All Enrollment Form [Page 1 of 3]

*First Name/Middle Initial	*Last Name	*Birthday (MM/DD/YYYY) ____ / ____ / ____	*Social Security Number ____ - ____ - ____
Street Address		City	State Zip Code
Home Phone (____) ____ - ____	Work Phone (____) ____ - ____	Cell or Other Phone (____) ____ - ____	
Email Address:		HPOG PRS #:	
Race - Select one or more: <input type="checkbox"/> Yes <input type="checkbox"/> No White <input type="checkbox"/> Yes <input type="checkbox"/> No Black/ African American <input type="checkbox"/> Yes <input type="checkbox"/> No Asian <input type="checkbox"/> Yes <input type="checkbox"/> No American Indian/ Alaskan Native <input type="checkbox"/> Yes <input type="checkbox"/> No Native Hawaiian of Other Pacific Islander Individual is Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Refugee Status: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Marital Status (check only one): <input type="checkbox"/> Currently Married <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married	
Citizenship Status (check one): <input type="checkbox"/> Born in the United States <input type="checkbox"/> Born in Puerto Rico, Guam, the U.S. Virgin Islands or Northern Marianas <input type="checkbox"/> Born abroad of American Parents or Parent <input type="checkbox"/> U.S. Citizen by Naturalization <input type="checkbox"/> Not a citizen of the United States Eligible to Work in the U.S.: <input type="checkbox"/> Yes <input type="checkbox"/> No Green card expiration date ____ / ____ / ____		Tribal Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Tribal affiliation: _____ Lives on the reservation: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse of tribal member: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Head of household: <input type="checkbox"/> Yes <input type="checkbox"/> No Number living in household at time of enrollment: ____ Number of Dependent Children: ____ Ages of Children: _____ Number of Children for Which Non-Custodial Parent: ____ Pregnant and/or Expectant: <input type="checkbox"/> Yes <input type="checkbox"/> No If pregnant/expectant, due date -- (MM/DD/YYYY): ____ / ____ / ____	
For the past 12 months, what were participant's approximate total earnings from work, including tips and overtime pay? <input type="checkbox"/> \$0 <input type="checkbox"/> \$20,000 to \$24,999 <input type="checkbox"/> \$1 to \$4,999 <input type="checkbox"/> \$25,000 to \$29,999 <input type="checkbox"/> \$5,000 to \$9,999 <input type="checkbox"/> \$30,000 to \$34,999 <input type="checkbox"/> \$10,000 to \$14,999 <input type="checkbox"/> \$35,000 or over <input type="checkbox"/> \$15,000 to \$19,999 <input type="checkbox"/> Don't know <input type="checkbox"/> Refused		For the past 12 months, how much was the participant's household's <u>TOTAL</u> family income, including the participant's earnings and other income and other income from all household members? <input type="checkbox"/> \$0 <input type="checkbox"/> \$40,000 to \$44,999 <input type="checkbox"/> \$1 to \$9,999 <input type="checkbox"/> \$45,000 to \$49,999 <input type="checkbox"/> \$10,000 to \$14,999 <input type="checkbox"/> \$50,000 to \$59,999 <input type="checkbox"/> \$15,000 to \$19,999 <input type="checkbox"/> \$60,000 to \$69,999 <input type="checkbox"/> \$20,000 to \$24,999 <input type="checkbox"/> \$70,000 or over <input type="checkbox"/> \$25,000 to \$29,999 <input type="checkbox"/> Don't know <input type="checkbox"/> \$30,000 to \$34,999 <input type="checkbox"/> Refused <input type="checkbox"/> \$35,000 to \$39,999	
Registrant has read and completed the informed consent and the decision is: <input type="checkbox"/> Yes <input type="checkbox"/> No Enrollment Date (MM/DD/YYYY): ____ / ____ / ____ Co-Enrolled at time of HCA Enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Enrollment Category: <input type="checkbox"/> Priority Group I: TANF <input type="checkbox"/> Priority Group II: At or Below 175% FPL <input type="checkbox"/> Priority Group III: Over 175% FPL	

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<p>*First Name/Middle Initial</p>	<p>*Last Name</p>
<p>Special Client Characteristics (at Time of Enrollment):</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No Individual with Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Foster Care Youth <input type="checkbox"/> Yes <input type="checkbox"/> No Homeless Individual <input type="checkbox"/> Yes <input type="checkbox"/> No Individual w/ Limited English Proficiency <input type="checkbox"/> Yes <input type="checkbox"/> No Ex-Offender <input type="checkbox"/> Yes <input type="checkbox"/> No Current Employee of Tribal Organization <input type="checkbox"/> Yes <input type="checkbox"/> No TANF Exhaustee </p> <p>Unemployment Insurance Compensation Recipient:</p> <p> <input type="checkbox"/> UI Claimant <input type="checkbox"/> UI Exhaustee <input type="checkbox"/> Not Claimant/Exhaustee </p>	<p>Public Assistance Receipt (at Time of Enrollment):</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No TANF <input type="checkbox"/> Yes <input type="checkbox"/> No General Assistance (GA) <input type="checkbox"/> Yes <input type="checkbox"/> No SNAP/Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No SSI <input type="checkbox"/> Yes <input type="checkbox"/> No SSDI <input type="checkbox"/> Yes <input type="checkbox"/> No Refugee Cash Assistance (RCA) <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No Subsidized Child Care/Voucher <input type="checkbox"/> Yes <input type="checkbox"/> No Housing Authority Resident If Yes: <input type="checkbox"/> Section 8 <input type="checkbox"/> Public Housing <input type="checkbox"/> SHA <input type="checkbox"/> KCHA <input type="checkbox"/> RHA <input type="checkbox"/> Yes <input type="checkbox"/> No LIHEAP <input type="checkbox"/> Yes <input type="checkbox"/> No Other, specify: _____ </p>
<p>Degree or certificates Received (check all that apply):</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No No Degree or Certificate <input type="checkbox"/> Yes <input type="checkbox"/> No Attained High School Diploma <input type="checkbox"/> Yes <input type="checkbox"/> No Attained GED or equivalent <input type="checkbox"/> Yes <input type="checkbox"/> No Attained Cert of Attendance/Completion <input type="checkbox"/> Yes <input type="checkbox"/> No Attained AA/ AS Degree <input type="checkbox"/> Yes <input type="checkbox"/> No Attained Other Post-secondary Degree or Certification <input type="checkbox"/> Yes <input type="checkbox"/> No Baccalaureate Degree (4-year) <input type="checkbox"/> Yes <input type="checkbox"/> No Occupational Skills Licensure, Certificate or Credential </p>	<p>Highest Level of Education Completed (Check only one):</p> <p> <input type="checkbox"/> 1st Grade <input type="checkbox"/> 1 Year of College <input type="checkbox"/> 2nd Grade <input type="checkbox"/> 2 Years of College <input type="checkbox"/> 3rd Grade <input type="checkbox"/> 3 Years of College <input type="checkbox"/> 4th Grade <input type="checkbox"/> Bachelor's Degree or Equivalent <input type="checkbox"/> 5th Grade <input type="checkbox"/> Education Beyond Bachelor's Degree <input type="checkbox"/> 6th Grade <input type="checkbox"/> Don't Know <input type="checkbox"/> 7th Grade <input type="checkbox"/> 8th Grade <input type="checkbox"/> 9th Grade <input type="checkbox"/> 10th Grade <input type="checkbox"/> 11th Grade <input type="checkbox"/> 12th Grade </p>
<p>First generation college student: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ever trained for a health care profession/occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	

Employment Information

<p>Ever worked for pay:</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Next Section) </p> <p>Currently employed?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If employed, does participant work for health care employer?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If employed, is participant self-employed?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If currently working, for last week of employment:</p> <p> Number hours worked for week: _____ Hourly wage: \$ _____ per hour </p>	<p>If not currently employed at the time of HPOG enrollment, reason for leaving last position:</p> <p> <input type="checkbox"/> Laid-off <input type="checkbox"/> Fired <input type="checkbox"/> Left voluntarily <input type="checkbox"/> Other reason If Other, specify: _____ </p> <p>If not working, for most recent job (for last week of employment):</p> <p> Number hours worked for week: _____ Hourly wage: \$ _____ per hour </p> <p>Current or Most Recent Previous Employer & Job Title</p> <p> Employer: _____ Job Title: _____ </p>
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*First Name/Middle Initial	*Last Name
Ever worked in a health care profession/occupation? ___Yes ___No	
If yes, specify health profession:	
___ 21-1091 Health Educators ___ 27-3091 Interpreters and Translators ___ 29-1190 Misc Health Diagnosing & Treating Practitioners ___ 29-2012 Medical and Clinical Laboratory Technologists ___ 29-2032 Diagnostic Medical Sonographers ___ 29-2034 Radiologic Technologist ___ 29-2040 Emergency Medical Technicians and Paramedics ___ 29-2070 Medical Records & Health Info Technicians ___ 29-2050 Health Practitioner Support Technologist/Technician ___ 29-2052 Pharmacy Technicians ___ 29-2055 Surgical Technologist ___ 31-1011 Home Health Aides ___ 31-1016 Patient Care Technician ___ 31-2012 Occupational Therapist Aides ___ 31-2022 Physical Therapist Aides ___ 31-9091 Dental Assistants ___ 31-9093 Medical Equipment Preparers ___ 31-9095 Pharmacy Aides ___ 31-9099 Healthcare Support Worker, All Others ___ Unknown	___ 21-1094 Community Health Workers ___ 29-1140 Registered Nurses ___ 29-2011 Medical and Clinical Laboratory Technicians ___ 29-2031 Cardiovascular Technologists and Technicians ___ 29-2033 Nuclear Medicine Technologists ___ 29-2035 Magnetic Resonance Imaging Technologists ___ 29-2060 Licensed and Vocational Nurses ___ 29-2090 Misc Health Technologists & Technicians ___ 29-2051 Dietetic Technicians ___ 29-2054 Respiratory Therapy Technicians ___ 31-1014 Nursing Assistants ___ 31-1015 Orderlies ___ 31-2011 Occupational Therapy Assistants ___ 31-2012 Physical Therapist Assistants ___ 31-9010 Massage Therapists ___ 31-9092 Medical Assistants ___ 31-9094 Medical Transcriptionists ___ 31-9097 Phlebotomists ___ 43-6013 Medical Office Clerk/Secretary/Specialists ___ 99-9999 Other: _____
Literacy Assessed at 8 th Grade Level or Above: ___Yes ___No	Numeracy Assessed at 8 th Grade Level or Above: ___Yes ___No

Alternative Contact Information

(Please List 1-2 People Who Can Help Locate You)

Alternative Contact 1

First Name	Last Name	Relationship to Participant
Street Address	City	State Zip Code
Home Phone (____) ____-____	Cell or Other Phone (____) ____-____	Email

Alternative Contact 2

First Name	Last Name	Relationship to Participant
Street Address	City	State Zip Code
Home Phone (____) ____-____	Cell/Other Phone (____) ____-____	Email

I certify that the information provided is true to the best of my knowledge. I am also aware that the information I have provided is subject to review and verification, and I may have to provide documentation to support this form. I allow release of this information for verification purposes and understand that it will be used to determine eligibility. I understand that receiving services is subject to the availability of federal funds. I have been advised of equal opportunity, appeal rights, and the Privacy Act of 1974.

Applicant Signature: _____ Date (MM/DD/YYYY): ____/____/____

Staff Name/Initials: _____ Date (MM/DD/YYYY): ____/____/____

HEALTH CAREERS FOR ALL ELIGIBILITY VERIFICATION CHECKLIST

PRIORITY STATUS

I. CURRENT TANF RECIPIENT

- ☐ E-JAS DEMOGRAPHIC SCREEN PRINTOUT

II. LESS THAN 175% FPL

A. Family Size

- ☐ PREVIOUS YEAR TAX RETURN
☐ RENTAL/LEASE AGREEMENT
☐ DSHS RECORDS
☐ MEDICAL COUPONS
☐ HOUSING AUTHORITY RECORDS
☐ NOTARIZED STATEMENT (attachment C)

B. Income

- ☐ MOST RECENT PAY STUBS FROM ALL WORKING FAMILY MEMBERS
☐ ESD PRINT OUTS FOR EACH WAGE EARNER
☐ PENSION RECORDS

(circle income level for family)

Family Size	175% FPL 6-Month	175% FPL Annual
1	\$10,211	\$20,423
2	\$13,764	\$27,528
3	\$17,316	\$34,633
4	\$20,869	\$41,738
5	\$24,421	\$48,843
6	\$27,974	\$55,948
7	\$31,526	\$63,053
8	\$35,079	\$70,158
For each addtl	\$3,553	\$7,105

Client

Source	Method	Total
Other Household Member: _____		
Source	Method	Total
Other Household Member: _____		
Source	Method	Total

III. AT/ABOVE 175% FPL & EXTENUATING CIRCUMSTANCE(S)

- ☐ VETERAN (see eligible veteran)
☐ DISABILITY (see disability)
☐ HOMELESS (see homeless)
☐ LIMITED ENGLISH/BASIC SKILLS (see LEP)
☐ LIMITED OCCUPATIONAL SKILLS
☐ LIMITED/INCONSISTENT WORK HISTORY
☐ SINGLE PARENT
☐ OTHER _____

ELIGIBLE TO WORK IN U.S.

(MUST DOCUMENT A OR BOTH B AND C)

A. Documents Identity and Employment

- ☐ US PASSPORT
☐ UNEXPIRED INS FORM I-551 STAMP OR GREEN CARD, I-766, I-94

B. Documents Identity

- ☐ FED, STATE OR LOCAL GOVT. ISSUED ID OR DL W/PHOTO
☐ US MILITARY CARD
☐ TRIBAL DOCUMENTS

C. Documents Employment

- ☐ ORIGINAL SSN CARD
☐ ORIGINAL OR CERTIFIED COPY OF BIRTH CERTIFICATE
☐ NATIVE AMERICAN TRIBAL DOCUMENTS
☐ EMPLOYMENT AUTHORIZATION DOC. FROM HOMELAND SECURITY

ELIGIBLE VETERAN

- ☐ DD214

INDIVIDUAL WITH A DISABILITY

- ☐ ADA CERTIFICATION/DR. VERIFICATION
☐ LETTER FROM DRUG/REHAB AGENCY
☐ CUSTOMER STATEMENT
☐ PHYSICIAN STATEMENT
☐ PSYCH DIAGNOSIS
☐ SSA DISABILITY RECORDS
☐ VA LETTER/RECORDS
☐ DVR LETTER
☐ WORKERS COMP RECORDS
☐ OTHER _____

HOMELESS

- ☐ SHELTER STATEMENT
☐ SOCIAL SERVICE AGENCY STATEMENT
☐ CUSTOMER STATEMENT (attachment C)
☐ E-JAS DEMOGRAPHIC SCREEN PRINTOUT
☐ PHONE VERIFICATION (attachment B)

LIMITED ENGLISH/LOW BASIC SKILLS

(LEVEL 6 OR BELOW)

- ☐ CASAS (score(s) _____)
☐ ENROLLMENT FORM/PRINTOUT FROM SCHOOL

INDIVIDUAL WITH A CRIMINAL RECORD

- ☐ DOCUMENTATION FROM JUVENILE JUSTICE
☐ DOCUMENTATION FROM ADULT CRIMINAL JUSTICE
☐ PHONE CALL VERIFICATION (attachment B)
☐ NOTARIZED STATEMENT (attachment C)
☐ BACKGROUND CHECK