

NEW JERSEY INTAKE AND INITIAL ASSESSMENT FORM A proud partner of the AmericanJobCenter® network**Today's Date:**UNDERLINED SECTIONS MUST BE COMPLETED. PLEASE COMPLETE ADDITIONAL FORMS IF INDICATED..

____/____/____

DOB: ____/____/____ MM/DD/YYYY**Gender:** Female Male**Last Name:****First Name:****Middle Initial:****Street:****City:****State:****Zip Code:****County:****Phone #:** () _____
Alt. Phone # () _____

Email:

Contact Preference: Postal E-mail
 Primary Phone Alt. Phone**Ethnic Heritage:** Hispanic or Latino Not Hispanic or Latino
 I choose not to disclose **Race:** Alaskan/American Indian
 Asian Black/African American White
 Hawaiian/Pacific Islander I choose not to disclose**Marital and Family Status** (choose all that apply) married divorced unmarried
Household: one-parent two-parent
 not a family member(single) other (dependent, child)
 optional: pregnant**School Status:**In-school: HS/secondary or Less alternative HS/Post-secondary
not attending school: HS dropout HS grad/equivalent
 16 or younger and have not attended last school year quarter**Employment Status** (choose one) employed not employed
 employed-received notice of termination
 not employed and not seeking work

If employed are you working (choose one)

 full-time part-time
 seasonal/temporary self-employed

If not employed and homemaker::

 Receiving support from spouse/former spouse
 Not receiving support from spouse/former spouse**Education Level (Choose highest only):** no grade ____ Yrs completed, (1-11) no diploma
 12th grade, no diploma HS equivalency 12th grade, HS grad
 disabled w/ Cert. IEP

Post-secondary/Vocational/Associate High School Plus:

 Post-secondary no degree: 1 year 2 years 3 years
 Vocational Certificate: 1 year 2 years 3 years
 Associate Degree: 1 year 2 years 3 years
 Other Degree: BA/BS Master's PhD**US Citizen:** Yes No Permanent Resident or Exp.Date: _____
Alien Reg.# (if applicable): _____**Individual with Disability:** Yes No Choose not to disclose [If Yes, please ask staff for Form D, which is kept confidential, and provide the following information: type of disability: hearing; vision; mental; mobility; cognitive//DD; learning; chronic health]**Migrant Seasonal Farmworker:** Yes No If Yes choose one: migrant seasonal farmworker migrant farmworker migrant food process worker
 dependent of migrant seasonal farmworker **Farmwork Type:** production and services food processing**Selective Service** (Males born on or after 1/1/1960 only) Yes No
 Selective Service #: _____**Native Language:** English other specify: _____**Military Service:** No Yes branch: _____

If Yes, use DVOP Checklist

 campaign veteran national guard reserve active duty
 transitioning vet discharge retirement other eligible
 active service From: _____ to: _____**Service Disability:** disabled not disabled special disabled
Receiving Veteran's benefits or assistance? No Yes
If Yes, specify: _____**Housing:** (choose one) aged out of foster care foster child
 homeless runaway
 own home rent
 choose not to disclose
 none of the above apply**Offender Status** - Have you been convicted of criminal offense? Yes No**Military Spouse** - Are you: active duty service member spouse service member widow
 disabled veteran spouse

If active duty spouse, has your income been affected by spouse's deployment?

 Yes NoDo you feel you have any barriers to employment, including customs, practices or beliefs, not described on this form, which you wish to disclose? Yes No
If Yes, please provide this information on Form D

Employment Preferences**Work Week:** full-time part-time both not seeking employment at this time**Duration:** regular (150 Days+) temporary (150 Days or Less) both**Minimum Salary:** \$ _____ Per _____ **Date Available to Work:** _____ / _____**Shift Preference:** Willing to work any shift? Yes No If No, which shift(s): 1st 2nd 3rd Split Rotating**Employment Objective:** _____ **Desired Job Title(s):** 1) _____

2) _____ 3) _____ 4) _____ 5) _____

Desired Employer(s): 1) _____ 2) _____ 3) _____**Acceptable Job Locations** (check one): 5 10 25 50 100 miles from Zip Code _____**Work History (Current/Last Employer):** job title: _____ employer: _____

street: _____ city: _____ state: _____

start date: _____ / _____ / _____ end date: _____ / _____ / _____ wage: \$ _____ per _____

reason for leaving: lack of work/layoff fired medical/health quit retired still employed strike
 other (specify) _____

job duties: _____

_____ If you wish to provide additional work history, inform staff person.

Additional Skills: _____**Professional Associations:** _____**Certificate/Special Licenses****Certificate/License:** _____ issued by: _____

issued date: _____ / _____ / _____ state: _____ country: _____

education-course of study: _____ degree: _____ school: _____ state: _____ country: _____**Driver's License****License:** No Yes State: _____**Type:** CDL-A CDL-B CDL-C Auto Moped**Transportation** I own a vehicle I have insurance I have access to: vehicle motorcycle bus/ rail none other**Endorsements:** passenger transport motorcycle hazardous materials tank vehicle school bus doubles/triples tank hazards air brakes*I attest that the information provided is true and accurate any misrepresentation may be grounds for termination from program(s). I further understand that being determined eligible for services and/or training does not necessarily entitle me to service/training*

Applicant Signature _____ Date _____ Parent/Guardian* _____ Date _____

Staff Signature _____ Date _____ Reviewed/Verified By _____ Date _____ *<18 only

Staff use only: WIOA Adult WIOA Dislocated Worker
 WDP Grant (Specify: _____)
 National Dislocated Worker Grant TANF
 SNAP
 GA
 CAVPAssistance start date: _____
Case #: _____**Income Status:** 100% LLSIL 70% LLSIL Not Disclosed Local Priority (Specify): _____**Barriers to Employment:** Youth In/Aged out of Foster Care Indian/Alaska native/Native Hawaiian Within 2yrs of TANF exhaustion ELL/Lower Level Literacy Substantial Cultural Barriers Low-Income Individual Displaced Homemaker Disability Homeless Individual Long-Term Unemployed Ex-Offender Eligible MSFW Single Parent Older IndividualWDB (County)
Code: _____ WIOA Youth ISY WIOA Youth OSY Low-Income
 High Poverty Area 5% Limitation**Additional Info:** Underemployed Not in Labor Force
 Interested in Nontraditional Employment**AOSOS ID#:** _____**OSY:** Foster Youth Dropout Homeless Not Attended Last Q
 Offender Low Income AND Basic Skills Deficient Pregnant/parenting
 Disability Low Income AND youth who Requires Add'l Assistance**ISY:** Low-Income AND: BSD English Language Learner
 Offender Homeless Foster Youth Pregnant/parenting
 Disability Youth who Requires Add'l Assistance**Referral Source:** DVRS LWD UI Public Assistance Agency CBO/FBO Self Other Local Area CSBG Employer HUD Adult Education Library Probation Parole Public Education Relative/Friend Re-entry/Second Chance Displaced Homemaker Program Family Success Center MSFW Grantee

Customer Acknowledgement Form

I have been provided copies of the following handouts explaining my rights as a Camden County One-Stop Career Center (CCOSCC) participant, including the right to file a complaint:

Your Right to File a Complaint
Types of Complaints and Filing Requirements
Equal Opportunity is the Law

CCOSCC staff explained these rights to me, gave me the opportunity to ask questions, and included the name, address, and telephone number for the CCOSCC Complaint Specialist and the State Equal Employment Opportunity representative.

Protection of Personal Identifiable Information

I understand that Personal Identifiable Information (PII) data and documents collected during the grant process will be physically safe from access by unauthorized individuals at all times and will be processed using issued equipment, managed information technology, and services at designated locations approved by the Employment and Training Administration.

Interagency Consent to Release Confidential Information

This is to certify that I give permission to release all requested interagency documentation to the Camden County One- Stop Career Center for the purpose of determining my eligibility for benefits and services, occupational training, work and employment activities, as well as to authorize payment for and monitoring of services.

I understand that my records are protected under federal regulations governing confidentiality and that they cannot be disclosed without my written consent, except in the very limited exclusion circumstances which pertain to 42 CFR Part 2. The information protected by 42CFR Part2 is any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program. "I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If my consent is revoked, I understand that my eligibility for benefits and services may be affected. In any event, this consent automatically expires two (2) years from the date recorded below.

Certification

I certify that the information provided on prior pages is true to the best of my knowledge and there is no intent to commit fraud. I am also aware that eligibility is subject to review and verification and I may be required to document its accuracy.

Customer Signature: *Click or tap here to enter text.*

Date: Click or tap to enter a date.

Customer Name (Please Print): Click or tap here to enter text.

