

Staff Referrals to Providers

The purpose of this option is to track referrals that staff members make on behalf of system registered individuals for provider services operating outside of system programs (i.e., WP or WIA). For example, staff can manage individuals who receive WIA services, but must create a staff referral for a skill assessment through Vocational Rehabilitation Services.

To properly utilize this referral tracking component, staff perform the following:

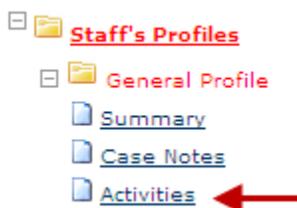
- Define the types of referrals that will be tracked
- Create referral details, including service provider information
- Record referral results

Note: A referral is a “form” used to introduce the individual to another program or provider of service and to provide a description of the type of service the individual is seeking from the provider.

Adding Referrals

To refer a client to a provider, you will create a Staff Referral to Providers.

1. Begin by assisting an individual in NEworks.
2. Select the Activities folder from the Staff Profile general folder.

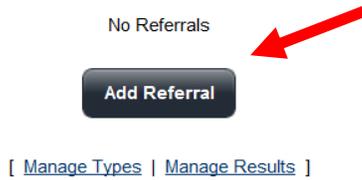


3. Then, select Staff Referrals to Providers on the Activities tab. This opens the Referral List page.

[Staff Referrals to Providers](#)

Select this option to create, edit and track referrals to local service providers for the selected Individual.

- At the bottom of the page, click the Add Referral button. This opens the Referral Entry form.



Completing the Form

There are three sections to the referral form; General Information, Type of Referral and Provider Information.

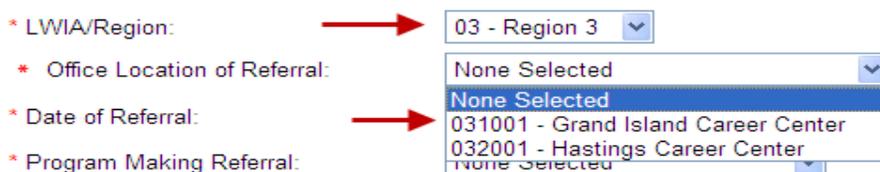
General Information

The General Information section pre-fills with the client User ID, SSN, Name, Address, Phone, and the Referral Staff User ID.

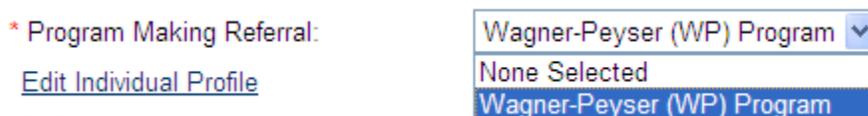
Complete the following fields:

- LWIA/Region
- Office Location of Referral
- Date of Referral
- Program Making Referral

- The LWIA/Region is the regional location of your AJC or NDOL location.
- Once you select a region, you can select your specific office location.



- Type in the date of referral or use the calendar icon to select a date.
- From the drop-down menu, select the Program Making the Referral. If the client is enrolled and active in a program such as WP, WIA, TAA or Veterans, those programs will appear in the menu.



5. If any of the individual information is incorrect, select the Edit Individual Profile link to update information on the General Information page

* Program Making Referral:

[Edit Individual Profile](#) 

Type of Referral

The Type of Referral section is where you will detail why you are making this referral.

There are two required fields in this section,

- Reason for Referral
- Additional information regarding Referral

You should use these fields to provide as much information as possible to the Provider when making the referral.

Note: The information provided in the “Additional information regarding referral” section will be sent directly to the Provider via email, so be very sure to use proper grammar and punctuation in order to portray yourself and the agency in a professional manner.

Type of Referral: Check all that apply 

Other Description:

* Reason for Referral:

* Additional information regarding referral:

Provider Information

The Provider Information section contains all of the contact information of the provider you to which you are sending the referral.

You can save valuable time and use the Search for Provider link to prepopulate data; provider information is added by the NEworks administrator. Additional providers may

be added per manager request. You may also manually enter all required fields in the form. To use the prepopulate option:

1. Begin by selecting the Search for Provider hyperlink. The Provider Search pop-up window will open.

[Search for Provider](#)

2. Here you can search for a provider one of two ways:
 - a. Select the radio button “Begin With” and type in at least the first three characters of the provider name and select the Submit button. A full list of providers matching your search opens in the Provider Name window.

The screenshot shows a search form with a dark sidebar on the left containing the text 'Search Type:' and 'Provider Search:'. The main area has two radio buttons: 'Begin With' (selected) and 'Contains'. Below them is a blue instruction: 'Please enter at least 3 characters to search for a Provider:'. A text input field contains 'voc' and is circled in red. A red arrow points to the 'Begin With' radio button. At the bottom are 'Submit' and 'Cancel' buttons.

| # | Provider Name | Region |
|------|---|--------|
| 2082 | Vocational Rehabilitation | State |
| -- | Provider Not Listed | |

- b. Select the “Contains” radio button and type at least three characters contained in succession within the provider name and select the Submit button.

The screenshot shows the same search form as above, but with the 'Contains' radio button selected. The text input field now contains 'reh' and is circled in red. A red arrow points to the 'Contains' radio button. The 'Submit' and 'Cancel' buttons are at the bottom.

| # | Provider Name | Region |
|------|--|--------|
| 2018 | VA Vocational Rehabilitation & Education | State |
| 2082 | Vocational Rehabilitation | State |
| -- | Provider Not Listed | |

3. Select the correct provider from the list. Many providers have different locations throughout the State, so pay close attention to your selection.
4. Use the drop-down menu to select the location; the address information will pre-fill the form.

Provider Information

Referral To: [Search for Provider](#)

* Provider Name: Vocational Rehabilitation

Location: **None Selected**

* Address 1: Vocational Rehabilitation
 Vocational Rehabilitation - Columbus
 Vocational Rehabilitation - Fremont
 Vocational Rehabilitation - Grand Island
 Vocational Rehabilitation - Kearney
 Vocational Rehabilitation - Lincoln
 Vocational Rehabilitation - Norfolk
 Vocational Rehabilitation - North Platte
 Vocational Rehabilitation - Omaha HWS
 Vocational Rehabilitation - Omaha West
 Vocational Rehabilitation - Scottsbluff
 Vocational Rehabilitation - South Sioux City
 Vocational Rehabilitation - Beatrice
 Vocational Rehabilitation - Omaha "F" Street

Address 2:

* City:

* State:

* Zip:(99999-9999)

Contact:

* Contact Person:

* Contact Phone: - - Ext.

Contact Email:

5. Select the Contact and the Contact Person's name, phone and email information will fill.

Contact: **None Selected** ▼

* Contact Person: **None Selected**
Manager

6. If applicable, select a Program/Service associated with the Provider.

Program/Service: **None Selected** ▼

None Selected

017 - Auto/Automotive Mechanic/Technician
 004 - Accounting Technology
 055 - Agricultural Technology
 014 - Auto/Automotive Body Repairer
 006 - Business Administration and Management
 165 - Criminal Justice
 163 - Academic Transfer
 107 - Technical Teacher Education (Vocational)
 068 - ABE/GED
 035 - Health and Medical Assistants
 084 - Special Vocational Needs

7. Select the Save button to send the referral.
 - a. An Email message will be sent to the Provider contact.

WIOA Services

BASIC SERVICES

- **Our services are not an entitlement program**
- Look at your hard skills, abilities, education level, job search efforts to see if you are employable.
- Soft skills: **attitude, cooperation, on time for appointments, completion of paperwork, follow-through, etc.**

CAREER SERVICES

- This is a lengthy process where you complete several assessments to help determine the best area of training for you.
- High wage, high skill and high demand

TRAINING SERVICES (for those who are college ready)

- Up to \$10,000 for school costs (tuition, books, tools, etc.) in a **two year** associates degree program that is approved by the Workforce Investment Board. Not a stepping- stone to 4 year or advanced degree.
- On-the-job training – WIOA pays a portion of your wages to an employer who is willing to hire and train you in a new occupation.
- Money for Support Services

Strings Attached

- **** Finish the training you started **and** graduate with a certificate or degree
- **** Get a full time job in the area of your training
- **** Stay employed full time in your area of training **and** stay in touch with your case manager monthly for 12 months.

Appointment only – no walk-ins.

Reschedules will wait a minimum of one month for another appointment. No/call, no/shows will wait a minimum of 2 months for another appointment.

Attachment C

One Stop Employment Solutions Pre-Application

| | | | | | |
|---|---------------|---|--|---|--|
| Last Name | | First Name | | Middle Initial | |
| Social Security Number | | | | | |
| Address | | | | | |
| City | | State | Zip | County | |
| Home Phone | | Message Phone | | Email Address | |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | | Individual with Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, with Impairment to Employment | | |
| Ethnicity (<i>Select only one</i>): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | | | Race (<i>Select one or more</i>): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White | | |
| Citizenship <input type="checkbox"/> US Citizen <input type="checkbox"/> Not A US Citizen <input type="checkbox"/> Lawfully Admitted Alien, Reg. # _____ | | | | | |
| Highest Level of Education Completed <input type="checkbox"/> Grade Level _____ <input type="checkbox"/> Attained GED <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> High School Graduate <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Education Beyond Bachelor's | | | | | |
| Current Education Status <input type="checkbox"/> Student, High School or Less <input type="checkbox"/> High School Graduate <input type="checkbox"/> Student, Attending Post High School <input type="checkbox"/> Out of School, HS Drop-out | | | | | |
| Last School Attended | | Date Last Attended School | | Currently Receiving Pell Grant <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Veteran <input type="checkbox"/> Yes, 180 Days or Less <input type="checkbox"/> Yes, More Than 180 Days <input type="checkbox"/> No | | Campaign <input type="checkbox"/> Yes <input type="checkbox"/> Yes, Vietnam Era <input type="checkbox"/> No | | Disabled Veteran <input type="checkbox"/> Yes <input type="checkbox"/> Yes, Special Disabled <input type="checkbox"/> No | |
| Recently Separated from Military <input type="checkbox"/> Yes <input type="checkbox"/> No | | Veteran Programs <input type="checkbox"/> Yes, VWIP <input type="checkbox"/> Yes, Labor Exchange <input type="checkbox"/> No | | Selective Service Status <input type="checkbox"/> Have Not Complied <input type="checkbox"/> Have Complied <input type="checkbox"/> Not Applicable | |

List your family members who **LIVE IN YOUR HOUSE**, relationship to you, age, income for last 6 months and source of income. **START WITH YOURSELF.**

| Name | Relationship | Age | Income for Last 6 Months | Source of Income |
|------|--------------|-----|--------------------------|------------------|
| | APPLICANT | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do You Receive:

Yes/No TANF (formerly ADC) Yes/No General Assistance
 Yes/No Supplemental Security Income Yes/No Food Stamps
 Yes/No Refugee Cash Assistance Yes/No Other _____

Current or Last Employer: _____

Address _____ City _____ State _____ Zip _____

Job Title and Duties _____

Begin Date _____ Last Employed Date _____ Hourly Wage _____
 (mm/dd/yy) (mm/dd/yy)

Reason for Leaving

Quit Fired Laid Off
 Health Unknown Other

Unemployment Compensation

Claimant Exhaustee Neither Claimant nor Exhaustee

Weekly Unemployment

\$ _____

Who referred you?

I understand the information I provide may be shared with participating partners (including, but not limited to Employment Services, Unemployment Insurance, Department of Health and Human Services and Vocational Rehabilitation) for the purpose of assisting me in employment and training related services. I understand that confidential information may be shared with agencies to which I have applied for assistance. The use of my Social Security number as identification in receiving and proving confidential information is authorized by registering for services. Information obtained from me may be used for statistical reporting purposes, but will not be disclosed in a manner personally identifiable to me. I certify that the information given is true and correct to the best of my knowledge. I have given my Social Security Number voluntarily.

 Applicant's Signature

 Date

 Staff Signature

 Date

The WIOA Adult and Dislocated Worker programs are equal opportunity programs. We will provide auxiliary aides or services upon request to provide individuals with disabilities an equal opportunity to participate in and receive the benefits of the services provided.

Equal Opportunity is the Law

It is against the law for this recipient of Federal financial assistance to discriminate on the following bases:

- Against an individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief; and
- Against any beneficiary of programs financially assisted under Title I of the Workforce Investment Act of 1998 (WIOA), on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his or her participation in any WIOA Title I-financially assisted program or activity.

The recipient must not discriminate in any of the following areas:

- Deciding who will be admitted, or have access, to any WIOA Title I-financially assisted program or activity; or
- Providing opportunities in, or treating any person with regard to, such a program or activity; or
- Making employment decisions in the administration of, or in connection with, such a program or activity.

What To Do If You Believe You Have Experienced Discrimination

If you think that you have been subjected to discrimination under a WIOA Title I-financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:

The recipient's Equal Opportunity Officer, Kimberly Taylor-Riley, Director, Lincoln Commission on Human Rights, 550 South 10th St, Suite 340, Lincoln, NE 68508, 402-441-7624, 402-441-6937, Email: ktaylor-riley@lincoln.ne.gov,

OR

The Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210

If you file your complaint with the recipient, you must wait either until the recipient issues a written Notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (see address above).

If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for the recipient to issue that notice before filing a complaint with CRC. However, you must file your CRC complaint within 30 days of the 90 day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient).

If the recipient does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with the CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

I, _____, acknowledge that I have received a copy of the Equal Opportunity is the Law Notice.

SIGNATURE

DATE

One Stop Employment Solutions Service Guide



1111 "O" Street, Suite 205
Lincoln, NE 68508
Monday - Friday
8:00am - 4:30pm
(402) 441-7111



UNITED STATES CITIZENSHIP ATTESTATION FORM FOR PUBLIC BENEFIT

For the purposes of complying with Neb. Rev. Stat. 4-108 through 4-114, I attest as follows:

_____ I am a citizen of the United States

OR

_____ I am a qualified alien under the Federal Immigration and Nationality Act. My Immigration status and alien number are as follows:
_____, and I agree to provide a copy of my USCIS (United States Citizenship and Immigration Services) documentation upon my request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME: _____

SIGNATURE: _____

Date: _____

Estimated Monthly Budget Name: _____

| HOME EXPENSES | |
|----------------------------|---|
| Mortgage/Rent | |
| Home/Rental Insurance | |
| Electricity | |
| Heat | |
| Water/Sewer/Trash | |
| Phone(s) | |
| Cable/Satellite | |
| Internet | |
| Other | |
| Total HOME EXPENSES | - |

| ENTERTAINMENT | | Budget |
|----------------------------|--|--------|
| Dining Out | | |
| Videos/DVDs/CD's | | |
| Movies/Theater/Concerts | | |
| Hobbies/Habits | | |
| Sports | | |
| Vacation/Travel | | |
| Other | | |
| Total ENTERTAINMENT | | - |

| TRANSPORTATION | | Budget |
|-----------------------------|--|--------|
| Vehicle Payments | | |
| Auto Insurance | | |
| Fuel | | |
| Repairs | | |
| Registration/License | | |
| Bus Fare | | |
| Other | | |
| Total TRANSPORTATION | | - |

| OBLIGATIONS | | Budget |
|--------------------------------|--|--------|
| Student Loan Payments | | |
| Other Loan payments | | |
| Credit Card payments | | |
| Alimony/Child Support payments | | |
| Other | | |
| Total OBLIGATIONS | | - |

| HEALTH | | Budget |
|-----------------------|--|--------|
| Health Insurance | | |
| Doctor/Dentist | | |
| Medicine | | |
| Life Insurance | | |
| Veterinarian/Pet Care | | |
| Other | | |
| Total HEALTH | | - |

| MONTHLY RESOURCES | | Budget |
|--------------------------------|--|--------|
| Your wages | | |
| Spouse / Other Wages | | |
| Alimony | | |
| Child Support | | |
| Unemployment Insurance | | |
| ADC/TANF | | |
| Food Stamps | | |
| Disability payments | | |
| Other Resources | | |
| Total MONTHLY RESOURCES | | - |

| DAILY LIVING | | Budget |
|------------------------------|--|--------|
| Groceries/Household supplies | | |
| Clothing | | |
| Dry Cleaning/Laundry | | |
| Salon/Barber | | |
| Child Care | | |
| Other | | |
| Total DAILY LIVING | | - |

| MONTHLY BUDGET SUMMARY | | Budget |
|--------------------------------|--|-------------|
| Total Monthly Resources | | 0.00 |
| Total Expenses | | 0.00 |
| NET | | 0.00 |

ASSESSMENT

Name: _____

Employment Goal: _____

Why are you interested in our services? _____

Educational Background

Dropout When: _____ Last Grade Completed: _____

What caused you to drop out? _____

GED When: _____ HS Graduate When: _____

College When: _____ Degree/major _____

List all your job related skills (e.g. type 20 wpm, computer skills, operate a forklift, etc.): _____

Attachment I

Follow-up procedure and contacts

As a recipient of federal funds, you are required to contact your case manager monthly for 12 months after you have graduated and secure employment. If you have not stayed in contact with your case manager, the names listed below will be called to get a message to you.

Contacts:

Name

Name

Address

Address

City State Zip

City State Zip

Phone Relationship

Phone Relationship

Name

Name

Address

Address

City State Zip

City State Zip

Phone Relationship

Phone Relationship

Applicant Name:

URBAN DEVELOPMENT DEPARTMENT
DAVE LANDIS, DIRECTOR

CHRIS BEUTLER, MAYOR

APPLICANT STATEMENT

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT I _____

I ATTEST THAT THE INFORMATION STATED ABOVE IS TRUE AND ACCURATE, AND UNDERSTAND THAT THE ABOVE INFORMATION, IF MISREPRESENTED, OR INCOMPLETE, MAY BE GROUNDS FOR IMMEDIATE TERMINATION AND/OR PENALTIES AS SPECIFIED BY LAW.

APPLICANT'S SIGNATURE DATE

ADDRESS

CITY STATE ZIP

OFFICE USE ONLY

The above applicant statement is being utilized for documents of the following eligibility criteria:

Participation Date Request Form

| | | | |
|--|------------------------------|-----------------------------|------------------------------|
| Date: | Click here to enter a date. | | |
| Applicant's Name: | Click here to enter text. | | |
| SSN: | Click here to enter text. | | |
| Participation Date Requested: | Click here to enter a date. | | |
| Case Manager: | Choose an item. | | |
| Reviewed By: | | | |
| Approved By: | | | |
| Elements Checked <i>(Reviewer Only)</i> | | | |
| Participant Info Sheet | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| EEO | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Applicant Rights | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| SSN: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Address: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Date of Birth: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Selective Service: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| Authorized To Work In U.S.A.: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Disability: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| Veteran Status: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| Employment Status: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Receiving U.I.: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| Highest School Grade: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| School Status: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Attending Any School: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Attachment K

DETERMINATION OF NEED FOR INDIVIDUAL CAREER SERVICES ADULT AND DISLOCATED WORKER

Name _____

Check all Basic Career Services received

- Intake
- Orientation
- Initial Assessment
- Labor Market Information
- Career Counseling
- Job Search and Placement Assistance
- Information and referral

Will the continued provision of Basic Career Services enable the customer to obtain or retain self-sufficient employment?

- Yes
- No

Check reason for Individual Career Services

- Occupations qualified for do not lead to self-sufficiency
- Occupations qualified for not in demand in local area
- Unable to perform previous occupation due to injury, illness or disability
- Current occupation does not provide for self-sufficiency
- Needs Individual Career Service to maintain self-sufficient occupation (specify Individual Career Service) _____
- Job search has been unsuccessful

Case Notes: _____

Signature of Case Manager

Date enrolled in Individual Career Services

**DETERMINATION OF NEED FOR TRAINING SERVICES
ADULT AND DISLOCATED WORKERS**

Name _____

Check reason(s) Training Services are needed

- Career Services will not alleviate barriers to employment
- Occupations qualified for do not lead to self-sufficiency
- Occupations qualified for not in demand in the local area
- Unable to perform previous occupation due to injury, illness or disability
- Current occupation does not lead to self-sufficiency
- Currently attending occupational skill training but cannot continue without WIOA financial assistance – see FND

Case Notes: See attached LMI supporting training decision

Signature of Case Manager Date

ELIGIBILITY CERTIFICATION ADULTS

Name _____,

Social Security number _____, has completed the
eligibility and verification process and has been certified eligible as a WIOA Adult:

Applied on: _____ Application updated on: _____

- Age
- Eligible to work in the US
 - Citizen
 - Authorized by INS
- Selective Service (if required)

Adult Priority Yes No

- Residence
- Veteran or eligible spouse
- Low Income/Public Assistance
 - Income
 - Family Size
 - Public Assistance
 - Member of household receiving/eligible to receive food stamps
 - Homeless
 - Foster child
 - Disability/own income at or below income guidelines for a family of one
- Not Low Income/Public Assistance Recipient

Staff Signature

Date

UNLIKELY TO RETURN STATUS FORM

Not Applicable

Applicable criteria:

Declining industry

Industry with limited job offers

Education or skill deficiency

Lack of job offers

Physical limitation

Seasonal work

Comments and supporting data: _____

Case manager

Date

Attachment N

Eligibility Certification Dislocated Workers

Name _____ Social Security number _____

_____ has completed the eligibility and verification process and has been certified eligible as a dislocated worker.

Applied on: _____ / Application updated on: _____.

Basic Services

- Age
- Eligible to work in the US
 - Citizen
 - Authorized by INS
- Selective Service (if applicable)
- Meets conditions of category 1, 2, 3, 4, 5, 6, or 7

- Category 1**
 - Has been terminated/laid off or has received notice of such, and
 - Is eligible for, receiving or has exhausted UI, and
 - Is unlikely to return to a previous industry or occupation.

- Category 2**
 - Has been terminated/laid off or has received notice of such, and
 - Has been employed for a sufficient duration to demonstrate attachment to the workforce but is not eligible for Unemployment Compensation due to insufficient earning or having performed services for an employer that were not covered under a State Unemployment Compensation law, and
 - Is unlikely to return to previous industry or occupation.

- Category 3**
 - Has been terminated or laid off, or has been notified of such as a result of any permanent closure of or any substantial layoff at a plant or facility or enterprise

- Category 4**
 - Employed at a facility at which the employer has made a general announcement that such facility will close within 180 days.

- Category 5**
 - Previously self employed (including employment as a farmer, rancher, or fisherman) but is unemployed as a result of general economic conditions in the community in which the individual resides or because of natural disasters.

- Category 6**
 - Is a Displaced Homemaker

- Category 7**
 - Is a Spouse of a member of the Armed Forces on active duty, and
 - Experienced a loss of employment as a direct result of relocation of the service member, or
 - Unemployed or underemployed and experiencing difficulty in obtaining or upgrading employment

Staff Signature

Date

Attachment O
print on letterhead

Authorization to Release Information

To: Southeast Community College
8800 "O" Street
Lincoln NE 68520

From: _____

WIOA Title I Training Recipient

Social Security Number

Street Address

City, State, Zip Code

Pursuant to the Family Educational Rights and Privacy Act (FERPA), the above named educational institution is hereby authorized to:

1. Release my social security number to a state unemployment insurance agency or other agency that has access to state unemployment insurance wage records for the purpose of determining my employment status for the purposes of monitoring performance standards under the Workforce Innovation and Opportunity Act of 2014.
2. Release information concerning my level of education attained at the above referenced educational institution to a state entity monitoring performance standards under the Workforce Innovation and Opportunity Act of 2014.

This release of information is voluntarily given in accordance with the Family Educational Rights and Privacy Act (FERPA) and information provided thereunder may only be used for the purposed described in paragraphs 1 and 2 above. This release shall continue in full force and effect until revoked by me in writing. A photocopy of this release shall be as effective as the original.

Signature Date

Witness Date

Follow-up procedure and contacts

As a recipient of federal funds, you are required to contact your case manager monthly for 12 months after you have graduated and secure employment. If you have not stayed in contact with your case manager, the names listed below will be called to get a message to you.

Contacts:

Name

Name

Address

Address

City State Zip

City State Zip

Phone Relationship

Phone Relationship

Name

Name

Address

Address

City State Zip

City State Zip

Phone Relationship

Phone Relationship

Applicant Name:

Authorization for Out-of-Area Job Search for Adults and Dislocated Workers

Name: _____

Social Security Number: _____

Fund: _____

Reason for Out of Area Job Search

- Wages are above local area average
 Occupation is not in demand in local area
 Unsuccessful job search

Date of Interview: _____

Position Title: _____

Destination: _____

Name of Company: _____

Assistance Authorized

| Service Authorized | WIA Amount | Non-WIA Amount | Total |
|--------------------|------------|----------------|-------|
| Lodging | | | |
| Transportation* | | | |
| Meals | | | |
| Totals | | | |

*Specify transportation assistance: _____

Comments: _____

Authorized Staff Signature_____
Date

**Authorization for Relocation Assistance
for Adults and Dislocated Workers**

Name: _____

Social Security Number: _____ Fund: _____

Destination: _____

Reason for Relocation

- Wages paid are above average for the local area
- Occupation is not in demand in local area
- Unsuccessful job search

Assistance Authorized

| Service Authorized | WIA Amount | Non-WIA Amount | Total |
|--------------------|------------|----------------|-------|
| Moving Expenses | | | |
| Equipment Rental | | | |
| Meals | | | |
| Transportation | | | |
| Lodging | | | |
| Housing Deposit | | | |
| Utilities Deposits | | | |
| Totals | | | |

Comments: _____

Authorized Staff Signature

Date

OJT Length Determination Form

Attachment Q.1

Client Name _____ Job Title _____ SOC Code _____

| O*NET SVP Range for OJT Training Occupation* | Maximum Training Weeks @ 40 hrs. per week | Maximum Training Hours | Reduction for Related Educational Training | Reduction for Related Work History | Total Hours Reduced for Education and Work History | Maximum OJT Hours | Employee Hourly Wage | Employer Wage Reimbursement Rate | Maximum OJT Amount |
|--|---|------------------------|--|------------------------------------|--|-------------------|----------------------|----------------------------------|--------------------|
| 1,2 (OJT not authorized) | | | Up to 25% | Up to 50% | | | | | |
| SVP 4-6 | 26 | 1040 | 0% | 0% | 0 | 1040 | \$11.40 | 75.00% | \$8,892 |
| | | | | | 0 | 0 | | | \$0 |
| | | | | | 0 | 0 | | | \$0 |
| | | | | | 0 | 0 | | | \$0 |

| ADJUSTMENT for RELATED EDUCATIONAL TRAINING (If applicable, only select one category) | Reduction | Description of Client Experience |
|---|-----------|----------------------------------|
| Experience Level | | |
| 2 or more years of related educational training | -25% | |
| 1 to 2 years of related educational training | -15% | |
| 6 Months to 1 year of related educational training | -10% | |
| ADJUSTMENT for RELATED WORK HISTORY (If applicable, only select one category) | | |
| Experience Level | | |
| 4 or more years of related work history | -50% | |
| 2 to 4 years of related work history | -25% | |
| 1 to 2 years of related work history | -10% | |

| Employer Reimbursement Rate is Based on Employer Size. | Number of Employees | Reimbursement Rate |
|--|---------------------|--------------------|
| | 1 to 50 | 90% |
| | 51 to 250 | 75% |
| | 251 or more | 50% |

_____ Case Manager

Adult and Dislocated Worker Entered Employment Rate

Time Frame: Participants who exited during the last three quarters of PY and the first quarter of next PY.

Exclusions

Excluded

- Participants who exited from WIOA for health/medical reasons, institutionalized, death, reservist called to active duty, family care, invalid SSN.
- Exclusions in 1st, 2nd & 3rd quarters after exit follow-up.
- Adults who were employed at date of participation.

Numerator - Success

Included

- Adults who were not employed at date of participation.
- And
- Adults who were employed in the 1st Quarter After Exit by Follow-up or UI Wage Records.

Denominator – Success & Failure

Included

- Adults who were not employed at date of participation.

Formula

Of those who were not employed at date of participation:

$$\frac{\text{Number of Adults who are employed in the 1st Quarter After the Exit Quarter}}{\text{Number of Adults who exited during the quarter}}$$

Considerations

Employment at the date of participation is based on information collected from the individual.

Be aware that participants who are working part time at participation will not count in this measure.

Be aware of exit timing. In some cases it makes sense to exit participants towards the end of a quarter, as they will only have to be employed for a short time in order to count as a success for this measure.

Programs that emphasize service to employed Adults need to be careful to ensure employment outcomes for the few Adults who were not employed at participation.

Make sure you have good contact information and good communication with the participant. If they do not show up on the UI Wage Record they can be counted as a success for the measure if employment is verified in the Adult/DLW Follow-up. Check the contact information prior to Exit to make sure that the contacts are still valid.

Adult and Dislocated Worker Employment Retention Rate

Time Frame: Participants who exited during the last quarter of PY and the first three quarters of next PY.

Exclusions

Excluded

- Participants who were terminated from WIOA for health/medical reasons, institutionalized, death, reservists called to active duty, family care, invalid SSN.
- Exclusions in the 1st, 2nds & 3rd Quarters after exit follow-up.
- Adults who were not employed in the 1st Quarter after exit by follow-up or UI Wage Records.

Numerator - Success

Included

- Adults who were employed in the 1st Quarter After Exit, Follow-up or UI Wage Records
- And
- Adults who were employed in the 2nd and 3rd quarters after exit follow-up or UI Wage Records.

Denominator – Success & Failure

Included

- Adults who exited during the Quarter and were employed in the 1st quarter after exit follow-up or UI Wage Records.

Formula

Of those employed in the 1st Quarter After Exit:

$$\frac{\text{Number of Adults employed in both the 2nd and 3rd quarters after the exit quarter}}{\text{Number of Adults who exited during the quarter}}$$

Considerations

Employment status at participation doesn't matter and employment in the 1st, 2nd and 3rd Quarters After Exit may be with different employers.

Those not found to be employed 1st quarter after exit are excluded.

Assist participants who are entering training to select appropriate training options that will lead to sustained employment and a demand occupation.

Make sure you have good contact information and good communication with the participant. If they do not show up on the UI Wage Record they can be counted as a success for the measure if employment is verified in the Adult/DLW Follow-up. Check the contact information prior to Exit to make sure that the contacts are still valid.

Adult and Dislocated Worker Average Earnings

Time Frame: Participants who exited during the last three quarters of PY and the first quart of next PY.

Exclusions

Excluded

- Participants who were terminated from WIOA for health/medical reasons, institutionalization, death, reservists called to active duty, family care, invalid SSN.
- Exclusions in 1st, 2nd & 3rd quarters after exit follow-up.
- Adults who were not employed in the 1st, 2nd and 3rd quarters after exit.
- Adults whose employment in either the 1st, 2nd, 3rd quarters after exit was determined solely from supplemental sources (follow-up) and not from wage records are excluded.

Numerator - Success

Included

- Wages from 2nd & 3rd quarters after exit. UI Wage Records.

Denominator – Success & Failure

Included

- Adults who exited during the quarter who were employed in the 1st, 2nd, and 3rd Quarters After Exit. UI Wage Records.

Formula

Of those employed in the 1st, 2nd and 3rd Quarters After Exit.

$$\frac{\text{Total post-program earnings (Quarter 2 + Quarter 3 after exit)}}{\text{Number of Adults who exited during the quarter}}$$

Considerations

Since supplemental data collection cannot be used for this measure, programs that lead to employment in non-covered industries may be at a disadvantage since they are excluded.

Adults whose Employment in the 1st, 2nd or 3rd quarter after exit that was determined from supplementary sources and not from wage records are excluded from this measure. However, be aware this will lower the total number in the denominator.

Programs that lead to part-time and seasonal employment will be at a disadvantage.

Do not register customers who are likely to lower your performance outcomes, unless you have a strategy in place to balance this with other customers who will have high gains than required.

Wage records will be the only data source for this measure. Acceptable wage record sources are a State's Unemployment Insurance wage records, and, if available electronically, Federal employment wage records, military employment wage records and other electronic administrative records.

Attachment S

ONE STOP EMPLOYMENT SOLUTIONS
 1111 O Street, Suite 205
 LINCOLN, NE 68508

ATTN: "Case Manager Name"
 441-xxxx

 Name (please print)

 Address

 City

 Zip

| | DATE | ODOMETER READING | | TOTAL MILES |
|---------------------------|------|------------------|--------|-------------|
| | | BEGINNING | ENDING | |
| Monday | | | | |
| Tuesday | | | | |
| Wednesday | | | | |
| Thursday | | | | |
| Friday | | | | |
| Saturday | | | | |
| Total Miles Driven | | | | |

| | DATE | ODOMETER READING | | TOTAL MILES |
|---------------------------|------|------------------|--------|-------------|
| | | BEGINNING | ENDING | |
| Monday | | | | |
| Tuesday | | | | |
| Wednesday | | | | |
| Thursday | | | | |
| Friday | | | | |
| Saturday | | | | |
| Total Miles Driven | | | | |

 Your Signature

 Authorized Staff Initials

Individual Training Account

Name _____ Social Security Number _____

Total amount budgeted for Training account: _____

| | | | | |
|--------------------|----------------|----------------|----------------|--------------|
| 2016 Year | Winter Quarter | Spring Quarter | Summer Quarter | Fall Quarter |
| Amount Budgeted | | | | |

| | | | | |
|--------------------|----------------|----------------|----------------|--------------|
| 2017 Year | Winter Quarter | Spring Quarter | Summer Quarter | Fall Quarter |
| Amount Budgeted | | | | |

| | | | | |
|--------------------|----------------|----------------|----------------|--------------|
| 2018 Year | Winter Quarter | Spring Quarter | Summer Quarter | Fall Quarter |
| Amount Budgeted | | | | |

I understand that the above figures will be amended based on availability of funding, my adhering to my employment plan and changes in my budget.

Student Signature _____ Date _____

Case Manager Signature _____ Date _____

WIOA Program – Worksite Agreement

The participant will perform job duties listed within this Agreement to attain the competencies outlined below. This Agreement expires after 500 hours of work.

| | | | |
|---|-----------------------------------|-------------------------|--------------------------|
| Worksite Name/Address/Phone | Worksite Supervisor’s Name | | YESS Case Manager |
| Participant Name/Phone | Job Title | Hours Authorized | Hourly Rate |
| Job Description (Essential Duties) | | | |
| Knowledge and Competencies to Attain | | | |

Acknowledgment

The Worksite agrees to the following responsibilities with the City of Lincoln's Youth Education & Support Services Program. This form is the signature page and certifies that the worksite supervisor has agreed to the requirements for the Program. By signing this Agreement, the worksite assures:

1. That no regular employee(s) wages, hours of work, or benefits are affected by this Agreement.

Work Experience does not qualify for Unemployment Benefits.

2. That no employee is currently in a layoff status from the same or substantially equivalent job.
3. That no regular unsubsidized employee was terminated and no involuntary reduction of the workforce occurred with the intention of filling vacancies with participants of the Youth Education & Support Services Program.
4. This position was not created in a promotional line that infringes in any way the promotional opportunities of currently employed workers.
5. That no existing contracts for services or collective bargaining agreements were impaired by this Agreement.
6. That no person shall, based upon race, color, religion, sex, national origin, disability, age, political affiliation or belief, be discriminated against, excluded or denied benefits in this program.
7. That each youth will be oriented to the worksite rules, policies and duties of the position.
8. That the worksite will comply with the Child Labor Laws.
9. That each youth will be provided with necessary instruction, supervision, tools and equipment to perform the work.
10. That a written daily record of the hours worked by each youth will be maintained.
11. That only those youth referred by the Youth Employment & Support Services Program will be employed under this Agreement.
12. No member of the supervisor's immediate family will be employed in that supervisor's department, division, section, or in any manner under which the supervisor would exercise any authority over the individual.
13. That program monitors will be allowed to examine, review and evaluate the worksite and the supervision provided.
14. That each youth employed under this Agreement will be evaluated by the supervisor according to the schedule provided.

Worksite Supervisor _____

(print full name)

Supervisor Signature

Date

Participant Signature

Date

WIA Youth Program Staff

Date

Attachment W

Work Experience Time Sheet For:

TIME CARD DUE 12/30/2015

NAME _____

WORKSITE NAME _____

PAY PERIOD: BEGINNING THUR 12/17/2015

ENDING WED 12/30/2015

| DATE | START TIME | BEGIN BREAK | END BREAK | END TIME | TTL HRS WKD |
|-------------------------|------------|-------------|-----------|----------|-------------|
| THURSDAY 12/17/2015 | | | | | |
| FRIDAY 12/18/2015 | | | | | |
| SATURDAY 12/19/2015 | | | | | |
| SUNDAY 12/20/2015 | | | | | |
| MONDAY 12/21/2015 | | | | | |
| TUESDAY 12/22/2015 | | | | | |
| WEDNESDAY 12/23/2015 | | | | | |
| THURSDAY 12/24/2015 | | | | | |
| FRIDAY 12/25/2015 | | | | | |
| SATURDAY 12/26/2015 | | | | | |
| SUNDAY 12/27/2015 | | | | | |
| MONDAY 12/28/2015 | | | | | |
| TUESDAY 12/29/2015 | | | | | |
| WEDNESDAY 12/30/2015 | | | | | |

Case Manager is not responsible for your reported hours. Your signature notates your agreement with the total hours.

PLEASE CIRCLE THE APPROPRIATE RATING

| | Unacceptable | Fair | Good | Excellent |
|----------------------------|--------------|------|------|-----------|
| Attitude | 1 | 2 | 3 | 4 |
| Attendance | 1 | 2 | 3 | 4 |
| Apperance | 1 | 2 | 3 | 4 |
| Ambition (initiative) | 1 | 2 | 3 | 4 |
| Accountability (honesty) | 1 | 2 | 3 | 4 |
| Acceptance (follows rules) | 1 | 2 | 3 | 4 |
| Appreciation for work | 1 | 2 | 3 | 4 |

Comments:

I certify said hours to be a full, true, and correct record of the hours worked during the above pay period.

Youth Signature _____

Date _____

Supervisor Signature _____

Date _____

Mail Or Deliver To: One Stop Employment Solutions Attn: LeAnn
1111 O St
Lincoln NE 68508

OR Fax To: (402) 441-6038

CITY OF LINCOLN/LANCASTER COUNTY
POST EMPLOYMENT INFORMATION

CONFIDENTIAL

Name: _____
(Last) (First) (Middle)

*****HOME ADDRESS*****

No./Street _____

City _____

State/Zip _____ Phone _____
(Home and/or cell)

*****PERSON TO CONTACT IN CASE OF EMERGENCY*****

Name _____

Address _____

Phone _____ Relationship _____

*****GENERAL INFORMATION*****

Social Security Number _____

Birth Date _____ Sex: M _____ F _____

Marital Status (check one) Married Single

* Do you have a disability which substantially limits a major activity? (check one)

- | | |
|----------------------------------|----------------------|
| 1. No | 5. Yes - Epilepsy |
| 2. Yes - Blind/Visually Impaired | 6. Yes - Paralysis |
| 3. Yes - Deaf/Hearing Impaired | 7. Yes - Cardiac |
| 4. Yes - Amputee | 8. Yes - Other _____ |

If Yes, do you require accommodation? Yes _____ No _____

If Yes, describe accommodation _____

* Of the following, of which racial/ethnic group do you consider yourself a member: (check one from each category)

** Ethnic - EEO (Check One)

1. Native American
2. Black/African-American
3. Asian or Pacific Islander
4. Hispanic/Latino
5. White

AND

** Ethnic - Grants (Check One)

- | | |
|--------------------------------------|--|
| 11. White | 15. Asian |
| 12. Hispanic or Latino | 16. Native Hawaiian Or Other Pacific Islander |
| 13. Black or African American | 17. Two or More Races |
| 14. American Indian or Alaska Native | |

* Used for Equal Employment Opportunity Census data information.

** Ask your payroll clerk for definitions of these categories.

Department _____ Date Hired _____

Employee's Signature _____ Date _____

ADA Interviewing Requirements

Instructions to the Applicant

In accordance with Americans with Disabilities Act, it is necessary that you read the position description which contains the "essential" job functions of the position for which you have applied. After reading the "essential" job functions, please complete the following information to indicate whether or not you can perform the "essential" functions and whether or not you would need any accommodations to perform these functions.

I have read the position description for: _____

- I can perform the "essential" job functions of the position without accommodation.
- In order for me to perform the "essential" job functions of the position, I would need the following reasonable accommodations.

- I cannot perform the "essential" job functions with or without reasonable accommodations.

Date: _____ Signature: _____

Type or print your full name

Instructions to the Interviewing Official

The applicant who has been offered the position must review the current position description which lists the essential functions of the position. The applicant needs to complete the form - indicating if any reasonable accommodations are needed to fulfill the "essential" job functions.

This original form should be attached to the Personnel Action form and forwarded to the Human Resources Department. A copy of this form may be retained for your own department's personnel files.

Please Do Not Fold

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

| | | | |
|---|---|----------|--|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A | |
| B | Enter "1" if: { <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. | B | |
| C | Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C | |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D | |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E | |
| F | Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit | F | |
| (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | | | |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. | | |
| | • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. | | |
| | • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child | G | |
| H | Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶ H | H | |
| | For accuracy, complete all worksheets that apply. { <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. | | |

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

| | | |
|---|---|---|
| Form <b style="font-size: 2em;">W-4 Department of the Treasury Internal Revenue Service | <h3>Employee's Withholding Allowance Certificate</h3> <p>▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> | OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; text-align: center;">2016</div> |
| 1 Your first name and middle initial Last name | | 2 Your social security number |
| Home address (number and street or rural route) | | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| City or town, state, and ZIP code | | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/> |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | 5 | |
| 6 Additional amount, if any, you want withheld from each paycheck | 6 \$ | |
| 7 I claim exemption from withholding for 2016, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ 7 | | |

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

| | |
|---|--|
| Employee's signature (This form is not valid unless you sign it.) ▶ | Date ▶ |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) 10 Employer identification number (EIN) |

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

| | | | |
|-----------|---|-----------|----------|
| 1 | Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over \$311,300 and you are married filing jointly or are a qualifying widow(er); \$285,350 if you are head of household; \$259,400 if you are single and not head of household or a qualifying widow(er); or \$155,650 if you are married filing separately. See Pub. 505 for details | 1 | \$ _____ |
| 2 | Enter: $\left\{ \begin{array}{l} \$12,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,300 \text{ if head of household} \\ \$6,300 \text{ if single or married filing separately} \end{array} \right\}$ | 2 | \$ _____ |
| 3 | Subtract line 2 from line 1. If zero or less, enter "-0-" | 3 | \$ _____ |
| 4 | Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) | 4 | \$ _____ |
| 5 | Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2016 Form W-4</i> worksheet in Pub. 505.) | 5 | \$ _____ |
| 6 | Enter an estimate of your 2016 nonwage income (such as dividends or interest) | 6 | \$ _____ |
| 7 | Subtract line 6 from line 5. If zero or less, enter "-0-" | 7 | \$ _____ |
| 8 | Divide the amount on line 7 by \$4,050 and enter the result here. Drop any fraction | 8 | _____ |
| 9 | Enter the number from the Personal Allowances Worksheet , line H, page 1 | 9 | _____ |
| 10 | Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 | 10 | _____ |

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

| | | | |
|----------|---|----------|-------|
| 1 | Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) | 1 | _____ |
| 2 | Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3" | 2 | _____ |
| 3 | If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet | 3 | _____ |

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

| | | | |
|----------|---|----------|----------|
| 4 | Enter the number from line 2 of this worksheet | 4 | _____ |
| 5 | Enter the number from line 1 of this worksheet | 5 | _____ |
| 6 | Subtract line 5 from line 4 | 6 | _____ |
| 7 | Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here | 7 | \$ _____ |
| 8 | Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed | 8 | \$ _____ |
| 9 | Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck | 9 | \$ _____ |

Table 1

Table 2

| Married Filing Jointly | | All Others | | Married Filing Jointly | | All Others | |
|---|-----------------------|---|-----------------------|--|-----------------------|--|-----------------------|
| If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from HIGHEST paying job are— | Enter on line 7 above | If wages from HIGHEST paying job are— | Enter on line 7 above |
| \$0 - \$6,000 | 0 | \$0 - \$9,000 | 0 | \$0 - \$75,000 | \$610 | \$0 - \$38,000 | \$610 |
| 6,001 - 14,000 | 1 | 9,001 - 17,000 | 1 | 75,001 - 135,000 | 1,010 | 38,001 - 85,000 | 1,010 |
| 14,001 - 25,000 | 2 | 17,001 - 26,000 | 2 | 135,001 - 205,000 | 1,130 | 85,001 - 185,000 | 1,130 |
| 25,001 - 27,000 | 3 | 26,001 - 34,000 | 3 | 205,001 - 360,000 | 1,340 | 185,001 - 400,000 | 1,340 |
| 27,001 - 35,000 | 4 | 34,001 - 44,000 | 4 | 360,001 - 405,000 | 1,420 | 400,001 and over | 1,600 |
| 35,001 - 44,000 | 5 | 44,001 - 75,000 | 5 | 405,001 and over | 1,600 | | |
| 44,001 - 55,000 | 6 | 75,001 - 85,000 | 6 | | | | |
| 55,001 - 65,000 | 7 | 85,001 - 110,000 | 7 | | | | |
| 65,001 - 75,000 | 8 | 110,001 - 125,000 | 8 | | | | |
| 75,001 - 80,000 | 9 | 125,001 - 140,000 | 9 | | | | |
| 80,001 - 100,000 | 10 | 140,001 and over | 10 | | | | |
| 100,001 - 115,000 | 11 | | | | | | |
| 115,001 - 130,000 | 12 | | | | | | |
| 130,001 - 140,000 | 13 | | | | | | |
| 140,001 - 150,000 | 14 | | | | | | |
| 150,001 and over | 15 | | | | | | |

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

City of Lincoln

Direct Deposit Authorization Agreement

I hereby authorize the City of Lincoln to initiate credit entries and to initiate, if necessary, adjustments for any credit entries in error to my account in the financial institution named below, and to credit or debit the same entries to such account.

Financial Institution: _____

City: _____ State: _____

Account No. _____ Checking Savings

This authorization is to remain in full force and effect until the City of Lincoln has received a new authorization form in such time and in such manner as to afford the City of Lincoln reasonable time to act on it. A new authorization form shall automatically cancel the existing form. **When changing from one financial institution to another, the old account should not be closed until you confirm that the change process has been completed.**

The undersigned hereby agrees that all entries hereunder are to be governed in all respects by the Rules of the National Automated Clearing House Association (NACHA), the rules of the Federal Reserve System and the laws of the United States, including the sanctions and embargo programs administered by the office of Foreign Assets Control ("OFAC"), as now or hereafter in effect and agrees to be bound thereby.

Employee Name (print): _____ Employee SSN: _____

Employee Signature: _____ Date: _____

Employee Department: _____ Employee Work Phone: _____

Your Direct Deposit information must be filled out completely with a voided check or a form printed from your bank or financial institution stating your routing and account number. Deposit slips generally do not work as they sometimes have a different routing number. Writing out information by hand also does not work as we need printed information. Valid routing numbers must start with a 0, 1, 2 or 3.

Send completed form to City Payroll

One Stop Employment Solutions

Debit Card Authorization

I do not have an account for Direct Deposit. I request that my pay be automatically deposited to a debit card.

I understand that it will be my responsibility to activate the card, keep the PIN number secure, and report if my card is lost or stolen.

Name (print)

Signature

SSN

Date

Attachment AC

One Stop Employment Solutions

Work Experience Checklist

Participant Name: _____

Fund Source: _____

Start Date: _____

- Worksite Agreement
- City of Lincoln Post Employment Form
- ADA Form
- W-4 Form
- Direct Deposit Form (voided check or deposit information attached)

OR

- Debit Card Authorization Form
- I-9 Form
- Copy of Social Security Card
- Copy of Photo ID

Case Manager

Date to OSES Finance

Attachment AD

A. WIOA Application Overview

1. Current WIA applications with no Exit Date will convert automatically to WIOA and no staff edits will be required
2. If Current WIA application is in “Incomplete” status, it will be converted but staff edits may be required
3. WIA applications with Exit Date 7/1/2010 or greater will also be converted to WIOA
4. WIA applications with Exit Date prior to 7/1/2010 will not be converted and sent to archive
5. When completing a WIOA application, there will be a new progress bar to show completion status.



6. Once an application is complete, you can click on application to access or use the Wizard and it will appear with tabs at the top like it does currently for WIA



7. There is still a checkbox to save a partial application
8. The system will not determine the eligibility of a “Partially Complete” app
9. When you click to Exit the Wizard, the application will only save tabs/sections where the Next button has been clicked to save info

B. WIOA Application

1. Start Tab

- a. The progress bar will show yellow if the tab/section is actively being processed, green if the tab/section is complete and grey if it is incomplete
- b. If the WIOA application was converted, it will show the WIA Converted Application ID to assist with cross referencing
- c. Staff can select single programs for eligibility at the beginning of WIOA application which can limit questions in the application and scope of services.

Application/Registration Information

?

Application Closed Never Enrolled: Close application, never enrolled

• **Application Date:** (mm/dd/yyyy)

Adult Basic Career Services Eligibility:

Adult Eligibility:

Adult Eligibility Date: (mm/dd/yyyy)

Dislocated Worker Eligibility:

Dislocated Worker Eligibility Date: (mm/dd/yyyy)

Youth Eligibility:

- d. Adult Basic Career (ABC) Service Eligibility – similar to WIA core
 - e. Adult/DW Eligibility – Similar to WIA Intensive
 - f. If entering a date prior to 7/1/2015 a popup message will display to inform that “Only WIOA eligibility rules will run based on this date.”
 - g. Farmworker status has been moved to the Employment section
2. Contact
- a. This tab/section has no changes
3. Demographics
- a. No changes, but American Indian/Alaskan Native & Hawaiian/Other Pacific Islander will have an effect in later section as a potential barrier
4. Veteran
- a. Veteran information will be collected in the same manner as on the general registration page
 - b. Changing status from Yes to No will wipe out all Veteran information for job seeker
 - i. Do not make this change unless absolutely sure the participant is not a vet
 - c. “Recently separated veteran (within the last 48 months)”
 - i. This criteria is different than what is required for WP
5. Employment
- a. Farmworker Status has moved to the employment page where it is more appropriate
 - b. Dislocated Worker categories descriptions have the significant differences bolded and there are two additional categories.

Dislocated Worker

?

Dislocated Worker Category:

Category 1: Terminated or laid off, or has received notice of termination or layoff, and is eligible for or has exhausted entitlements to UC, and is unlikely to return to previous industry or occupation.

Category 2: Terminated or laid off, or has received notice of termination or layoff, and has been employed for sufficient duration (based on state policy) to demonstrate workforce attachment, but is not eligible for UC due to insufficient earnings, or the employer is not covered under the state UC law, and is unlikely to return to previous industry or occupation.

- c. Instead of radio buttons, there are now checkboxes for DW verification.
 - i. You can select more than one DW verification if applicable and they do not have to match the DW category

| Dislocation Category Verification | |
|-------------------------------------|--|
| <input checked="" type="checkbox"/> | Cat 1 or 2: Separation Notice from Employer |
| <input type="checkbox"/> | Cat 1 or 2: UC Records |
| <input type="checkbox"/> | Cat 3: WARN notice or letter of profiled authorization from the State WIA Admin Dept. or other accepted documentation |
| <input type="checkbox"/> | Cat 4: Documentation of "General Announcement." |
| <input type="checkbox"/> | Cat 5: Receipt of Notice of foreclosure or intent to foreclose. |
| <input type="checkbox"/> | Cat 5: Proof of failure of the farm, business or ranch to return a profit during preceeding 12 months. |
| <input type="checkbox"/> | Cat 5: Entry of individual into bankruptcy proceedings. |
| <input type="checkbox"/> | Cat 5: Inability to make payments on loans secured by tangible business assets. |
| <input type="checkbox"/> | Cat 5: Inability to obtain capital necessary to continue operations. |
| <input type="checkbox"/> | Cat 5: A debt-to-asset ratio sufficiently high to be indicative of the likely insolvency of the farm, ranch or business. |

- d. Number of weeks unemployed-if youth has never worked, you may enter 99.
- e. Layoff Industry and ONET code are new but not currently required fields

6. Education

- a. Attending any School (per state definition) – required field
 - i. New blue text stating “Excluding Adult Education”
 - ii. This will determine the status of In School or Out of School for Youth

| Educational Information | |
|--|--|
| • Current Highest School Grade Completed (from registration): | High School Diploma |
| • Federally Reported Highest School Grade Completed: | Attained High School Diploma |
| | [Verify] |
| | <input checked="" type="checkbox"/> Self Attestation |
| • School Status: | In-school, post High School |
| | [Verify] |
| | <input checked="" type="checkbox"/> School records |
| • Attending any School (per state definition) <i>Excluding Adult Education:</i> | Yes |
| | [Verify] |
| | <input checked="" type="checkbox"/> School Records |

7. Public Assistance

- a. Categories are grouped by
 - i. Individual or Family member receiving:
 - ii. Individual receives, or in the last 6 months, received:
 - iii. Individual currently meets
- b. Refuge cash assistance no longer reportable

8. Barriers

- a. Categories are split between individual barriers and barriers to employment
- b. New barriers include
 - i. English Language Learner
 - ii. If receiving TANF, are they within two years of exhausting TANF lifetime eligibility
 - iii. Hawaiian Native
 - iv. American Indian/Alaskan Native
 - v. Substantial cultural barriers
 - vi. Meets long term unemployment definition
 - vii. Older Individual
 - viii. Meets Governor’s special barriers to employment
 - 1. This is 5% of 5%
 - ix. Youth – Youth requires additional assistance...

- 1. Not the same as WIA
- x. Youth – Out of Home Placement
 - 1. Removed from home and placed with relative

9. Family Income

- a. No change

10. Miscellaneous

- a. All configurable items presented

11. Eligibility and Grants

- a. Application meets the definition for low income:
- b. Green highlight for eligible Program

| Applicant Eligibility | | | | | |
|---|--------------|----------|----------------------|----------------------------|-----------------------------------|
| Applicant meets the definition for low income: Yes | | | | | |
| Income Table: Income Table | | | | | |
| Program | Eligible | Priority | Exception/Limitation | Reason(s) Not Eligible | Action |
| ABC Services | Undetermined | | | No ABC Eligibility Date. | <input type="checkbox"/> Inactive |
| Adult | Yes | LI | | | <input type="checkbox"/> Inactive |
| Dislocated Worker | Yes | | | | <input type="checkbox"/> Inactive |
| Youth | Undetermined | | | No Youth Eligibility Date. | <input type="checkbox"/> Inactive |
| VET = Veteran, BSD = Basic Skills Deficient, PA = Public Assistance, LI = Low Income, SLP = Additional Priorities | | | | | |

- c. Priority column with Legend below for assistance
- d. Exception/Limitation for 5% Exception rule
- e. WIOA Grant Eligibility
 - i. National Dislocated Worker Grant NDWG takes place of NEG
- f. Link to show previous WIA Eligibility no longer recorded in WIOA

CHARGE OF WIOA COMPLAINT/GRIEVANCE UNDER THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

WIOA TITLE I SERVICE PROVIDER – CITY OF LINCOLN – COMPLAINT FORM

| | | | | |
|---|------------------|-------|-----|--------|
| Name | Telephone Number | | | |
| Street Address | City | State | Zip | County |
| NAMED BELOW IS THE WIOA TITLE I: EMPLOYEE, ORGANIZATION, SERVICE PROVIDER, OR OTHER who I have a complaint or grievance against in regards to services provided under the Title I Workforce Innovation and Opportunity Act. | | | | |
| Name | Telephone Number | | | |
| Street Address | City | State | Zip | County |
| Name | Telephone Number | | | |
| Street Address | City | State | Zip | County |
| DATE MOST RECENT OR CONTINUING GRIEVANCE OR COMPLAINT TOOK PLACE (Month, Day, Year). Complaints must be filed within 180 days of the alleged occurrence. | | | | |
| PLEASE DESCRIBE IN DETAIL YOUR COMPLAINT/GRIEVANCE: Include a concise statement of facts and pertinent dates (attach additional sheets if necessary). When appropriate, please cite the provisions of WIOA regulations, grants or other agreements under WIOA believed to have been violated. Copies of documents referred to in your complaint must be attached. | | | | |
| PLEASE STATE THE RELIEF OR REMEDIAL ACTION YOU ARE SEEKING: | | | | |
| Are you represented by an attorney or other representative? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If yes, who: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Name Address Phone Number </div> | | | | |
| Has this complaint been filed anywhere else such as the NEOC or EEOC? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If yes, where? _____ | | | | |

Signature

Date

Notary

Date

Please deliver the complaint with the original signature to: Vicki Leech, WIA One Stop Operator, 1111 "O" Street, Suite 205 Lincoln, NE 68508

Attachment AE

Accommodation Request

This form is used to record requests for accommodation by an individual/registrant, applicant, participant or employee.

Name of Individual Requesting Accommodation

Date Accommodation Requested

Accommodation Requested:

Individual Signature

Date

Program Manager Signature

Date

Accommodation Provided Yes No

Describe Accommodation Provided:

OSES Staff Signature

Date



Attachment AE

Accommodation Request

This form is used to record requests for accommodation by an individual/registrant, applicant, participant or employee.

Name of Individual Requesting Accommodation

Date Accommodation Requested

Accommodation Requested:

Individual Signature

Date

Program Manager Signature

Date

Accommodation Provided Yes No

Describe Accommodation Provided:

OSES Staff Signature

Date

