SAN BERNARDINO COUNTY
Workforce Development

Application Disclosure Documents - Youth

290 N. D Street, Suite 600
San Bernardino, CA 92415
(909) 387-9859

NAME (First, Middle Initial, Last):	Last 4 SSN:
Youth Provider:	

FOLLOW-UP AGREEMENT

Workforce Innovation and Opportunity Act (WIOA) is a federally funded program, which requires monitoring the progress of our participants, including employment verification, for one year after exiting the program.

Participant Release of Information Statement:

As an enrollee in the WIOA program, I agree to notify your office if my address changes. I also agree to provide information including my employer's name, address, and phone number, the number of hours I am working, my start date, my rate of pay, and my job description.

I hereby give permission to the San Bernardino County Workforce Development Department to perform employment status checks on 'The Work Number' using my social security information for the full duration of my participation in the WIOA program.

I also hereby give permission to my employer to release information regarding my employment and earnings to the San Bernardino County Workforce Development Department's WIOA program. I understand that the information I provide will be kept strictly confidential.

Nepotism – Please read and answer the questions below:

1. Is a member of your immediate family (spouse, parent, child, brother, sister, in-law, uncle, aunt, nephew, niece, first cousin, step-parent, step-child) an elected City or County official?
   ☐ Yes ☐ No If you answered "yes," what is his/her name, elected title and relationship to you?

   _____

2. Is a member of your immediate family (spouse, parent, child, brother, sister, in-law, uncle, aunt, nephew, niece, first cousin, step-parent, step-child) an employee of a City, County or WIOA-funded organization?
   ☐ Yes ☐ No If you answered "yes," what is his/her name, organization, position and relationship to you?

   _____

Contact Information – Please list two people who do NOT live in your household and will always know how to contact you.

	FIRST AND LAST NAME	EMAIL ADDRESS	TELEPHONE NUMBER
1.			
	ADDRESS	CITY	STATE AND ZIP CODE
	FIRST AND LAST NAME	EMAIL ADDRESS	TELEPHONE NUMBER
2.			
	ADDRESS	CITY	STATE AND ZIP CODE

☐ **I have read and understand the Department of Workforce Development's Follow-Up Agreement.**

Initial Here

Application Disclosure Documents - Youth

Participant Name:_____

ORIENTATION CHECKLIST

Orientation was conducted by: _____

I certify that the following items have been explained, in detail, on this date. Please check all that apply and initial.

- ☐ Complaint & Grievance Procedure
- ☐ Equal Opportunity Information and Discrimination Complaint Procedures
- ☐ Services for Youth 18+ Available at Nearest America's Job Center (AJCC)
- ☐ Youth Responsibility and Expected Outcomes
- ☐ Skill Attainment
- ☐ Employment Procedures
- ☐ Stipend Policy
- ☐ Wokshop Expectations
- ☐ Basic Skills Deficiency
- ☐ Goals and Barriers
- ☐ Individual Service Strategy (ISS)
- ☐ Assessment Procedures
- ☐ Minimum Wage

☐ **I have read and understand the items checked above.**
Initial Here

RELEASE & AUTHORIZATION FOR USE OF IMAGE, NAME, VOICE, AND/OR INTERVIEW

I hereby irrevocably grant to the San Bernardino County Workforce Development Department ("County") the absolute and irrevocable right to now and in the future *(check all that apply)*:

☐ Create and obtain images, photographs, video, audio, interviews, stories, personal histories, and any other recordings or documents, in any now known or future media, of my name, image, voice, likeness, personal information, or other items ("Recordings") related to the services provided by the County pursuant to the Workforce Innovation and Opportunity Act (WIOA).

☐ Use, publish, distribute, copy or transmit these Recordings either in whole or in part, individually or in connection with other material, in any and all media, including but not limited to, presentations, displays, brochures, and other official materials, including the Internet, to promote the WIOA program, without restriction as to alteration; and to use my name in connection with any Recordings if the County so chooses:

☐ Use my story and quotes, should I provide them to the County, about myself, in presentations, displays, brochures, and other official materials, including the internet, to promote the WIOA program, without restriction as to alteration; and to use my name if the County so chooses.

☐ The County shall own all right, title, and interest to the Recordings, including my story and quotes. I hereby waive any inspection or approval of use. I also waive and release the County from any claims based on invasion of privacy, right of publicity, defamation, false endorsement, or claim of visual or audio alteration or faulty mechanical reproduction.

☐ My initials indicate this form is complete and read by me (or to me) and I am in agreement with the items checked and that no promise or representations of any kind have been made to me.
Initial Here

☐ I wish to opt out of the Media Release/Authorization.
Initial Here

MEDICAL RELEASE

If the participant is under 18 years of age, please complete the following:

I _____ the undersigned parent and/or legal guardian of _____ whose date of birth is _____ do hereby authorize medical and/or surgical treatment by a State of California licensed medical doctor (M.D.), and/or a State of California licensed hospital and/or licensed hospital emergency room and/or a private practice office operated by a State of California licensed medical doctor (M.D.), duly certified and licensed and/or their representatives as agent(s) for the undersigned to consent to any X–ray, laboratory, anesthetics, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of a licensed medical doctor (M.D.) as per the provisions of the Medical Practice Act and who is on the staff of the accredited hospital, whether such diagnosis or treatment is rendered at the office of the treating physician or at any accredited hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority, consent, and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his medical and surgical judgement may deem advisable pursuant to the provisions of § 25.8 of the Civil Code of California.

In addition, you are authorized to release and/or to receive any and all medical records and/or related medical information pertaining to and/or aiding in the treatment rendered the minor named above with regard to the minor/minor's industrial accident/injury.

Family Doctor: _____ Phone number: _____

_____ _____
Parent/Legal Guardian's Signature Date

_____ _____
Signature of Witness Date

If participant is 18 years old or older, please provide an emergency contact. In case of emergency, please notify:

Name: _____ Relationship: _____
Complete Address: _____
Phone number: _____
Please list personal physical information that hospital or physician should be aware of in case of illness or injury (i.e., diabetic, drug reactions, heart condition, drug/medications currently taking, allergies, etc.).

PROGRAM COMPLAINT AND GRIEVANCE PROCEDURES

If you believe you have been adversely affected by a decision or action of the local workforce system that is in violation of the Workforce Innovation and Opportunity Act (WIOA), you may file a grievance or complaint at any time within one year of the alleged violation using the process described below.

If your complaint involves discrimination, please use the *"Discrimination Complaint Procedures"* form.

1. Ask to speak with a Program Supervisor within 90 days of the day the incident occurred.
   - A supervisor will contact you within three (3) business days to discuss your complaint or grievance
   - If you are not satisfied with the decision, go to Step 2

2. Ask to speak with the Program Director about your complaint.
   - The Program Director will contact you within three (3) business days
   - If you are not satisfied with the decision, go to step 3

3. Ask to speak to the Workforce Development Department Staff Analyst over the WIOA Youth Program.
   - The Staff Analyst will contact you within three (3) business days of step 2
   - If you are not satisfied with the decision, go to step 4

4. Ask to speak with a Workforce Development Department Administrative Supervisor about your complaint or grievance.
   - The Administrative Supervisor will contact you within seven (7) business days of step 3
   - If you are not satisfied with this decision, go to Step 5

5. The Administrative Supervisor will arrange a meeting for you to discuss your complaint or grievance with staff, witnesses and your service provider.
   - The meeting will take place within 25 business days of the day you spoke with the Program Supervisor about your grievance or complaint
   - If you are not satisfied with the decision, go to Step 6

6. Complete the Program Complaint and Grievance Request for Hearing 181C form, available from the Staff Analyst. You have the right to a hearing on any grievance or complaint to be conducted by an impartial hearing officer within 30 days of the submission of the 181C form. Send the completed form to:

   Adriana Escobedo
   Administration Manager/Equal Opportunity Officer RIVCO,
   Workforce Development Division
   1325 Spruce Street, Suite 400,
   Riverside, CA 92507

   You may file an appeal or request a separate review by Employment Development Department (EDD) if you experience an incident of restraint, coercion, or reprisal as a result of filing a complaint. To file an appeal, please send your request to: Chief, Compliance Review Office, MIC 22-M, Employment Development Department, P.O. Box 826880, Sacramento, CA 94280-0001

For technical assistance with filing your complaint, contact the Equal Opportunity Officer at (909) 383-9928. TTY users can contact the Equal Opportunity Officer through the California Relay service (711).

_____ **I have read and understand the Workforce Development Department's program complaint and grievance procedure.**
Initial Here

EQUAL OPPORTUNITY IS THE LAW

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

- Against any 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 Innovation and Opportunity Act (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;
- 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 (or person whom the recipient has designated for this purpose); 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 CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

For information or to file a complaint with the recipient, contact:

Fred Burks, Equal Opportunity Officer
San Bernardino County Workforce Development Department, 290 North D Street – Suite 600, San Bernardino, CA 92415 Phone: (909) 387-9845,
California Relay Service: 711 Fax: (909) 889-2460
fburks@wdd.sbcounty.gov

☐ **I have read the above and understand my equal opportunity rights under the Workforce Innovation and Opportunity Act.**

Initial Here

DISCRIMINATION COMPLAINT PROCEDURES

If you believe you have experienced discrimination in your Workforce Innovation and Opportunity Act (WIOA) program, activity or service, you may file a complaint using the following process.

1. Ask to speak with a Program Supervisor within 90 days of the incident.
   - A supervisor will contact you within three (3) business days to discuss the incident
   - If you are not satisfied with the decision, go to Step 2

2. Ask to speak with the Program Director about the incident.
   - The Program Director will contact you within three (3) business days of the day you spoke with the supervisor about the incident
   - If you are not satisfied with the decision, go to Step 3

3. Ask to speak to the Workforce Development Department Staff Analyst over the WIOA Youth Program.
   - The Staff Analyst will contact you within five (5) business days of the day you spoke with the Program Director about the incident
   - If you are not satisfied with the decision, go to Step 4

4. Ask to speak to the Equal Opportunity Officer of the Workforce Development Department about the incident.
   - The EEO will contact you within seven (7) business days of the day you spoke with the Workforce Development Staff Analyst about the incident
   - If you are not satisfied with the decision, go to Step 5

5. Obtain the "*Discrimination Complaint Information Form 190"* from the EEO. Send the completed form to:

   Fred Burks, Equal Opportunity Officer
   San Bernardino County Workforce Development Department
   290 North D Street, Suite 600
   San Bernardino, CA 92415

The Equal Opportunity Officer must receive your written complaint no later than 180 days from the date you believe the discrimination happened.

Initial Here

I have read and understand the Workforce Development Department's discrimination complaint procedure. I understand that if I feel I have experienced discrimination, I may use this procedure, or I may send a written complaint directly to the Equal Opportunity Officer at the address above.

Participant Name:_____

PARTICIPANT RELEASE

As a Workforce Innovation & Opportunity Act (WIOA) participant, you may participate in the activities and programs of the San Bernardino County America's Job Center of California (AJCC) Partner agencies and other local service providers. Your signature below authorizes the San Bernardino County Department of Workforce Development Department (WDD) to exchange information about you with the following agencies, as needed, and from these agencies to the WDD:

- ☐ San Bernardino County AJCC Partner agencies
- ☐ Eligible Training Providers
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

All information exchanged between the above agencies will be held in the strictest confidence. A written request will be required to revoke this authorization.

Participant Statement:

☐ I authorize the Agency/Institution/Individual Provider checked above to release information about me to the San Bernardino County Department of WDD. I understand this release will remain in effect unless I choose to revoke it. This form was completed in its entirety and was read by me (or read to me) prior to signing.

☐ I decline authorization.

PARTICIPANT CERTIFICATION

My signature below indicates that I have been informed of and understand the information contained in this form.

PARTICIPANT NAME (PRINT):	PARTICIPANT SIGNATURE	DATE

Funding for this program is provided by the San Bernardino Workforce Development Board (WDB). This WIOA Title-1 financially assisted program or activity and the WDB are Equal Opportunity Employers. Auxiliary aids and services are available upon request to individuals with disabilities. For federal funding disclosure information, visit Workforce.SBCounty.gov/about/ffd/.