

AMERICAN INDIAN CENTER OF ARKANSAS

400 W. Capitol, Ste 1611
Little Rock, AR 72201

CLIENT QUESTIONNAIRE

Name: _____ E-MAIL _____ SSN (Last 4): _____

How did you hear about AICA? Newspaper _____ Radio _____ TV _____ Other _____

Are you currently unemployed? Yes _____ No _____

Reason why unemployed:

- Fired* Maternity leave Laid off Re-entry into Labor Force*
 Never worked other* Resigned* Enrolled in school

*Explain: _____

If you are employed, how many hours do you work per week: _____ Rate of Pay: _____

List your current Degrees, Certificates, License, or Job Skills and rate them individually.	HIGH	AVER	LOW

What is your employment goal?

Does it require any kind of training? Yes _____ No _____

If approved for either AICA WIOA, Section 166 program this questionnaire will help the case manager or employment development specialist in evaluating what steps are needed in helping you obtain employment.

Workforce Innovations and Opportunity Act (WIOA) Application

American Indian Center of Arkansas
 400 W. Capitol, Ste 1611
 Little Rock, AR 72201
 501-666-9032/800-441-4513 Fax: 501-666-5875
 www.AICAgo.org

Indian & Native American Programs
 Workforce Innovations and Opportunity Act, Section 166 ● DOL/ETA/DINAP

Please print in ink. Where answer boxes are used, place an "x" in only one box.

IDENTIFICATION

Name (Last, first, middle, & maiden)	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB (m/d/y)	Social Security Number - - -
Residential Address (Number, street, apt. #, City, 6c. State & Zip Code)				County
Mailing Address (Street, City, State & Zip Code)				
Home/Cell Phone Number:	Message phone number:	E-Mail address:		

ELIGIBILITY

U.S. Citizen? Yes No Tribal Affiliation: _____ Agency: _____

If you are male and born on or after January 1, 1960, and/or 18 or older, have you registered for the Selective Service? Yes No

AIC OFFICE USE ONLY (1-847-688-6888) Selective Service Number: _____ Verified by: _____

Have you or your spouse served in the military? Yes No

Are you currently employed? Yes No If yes, are you in need of upgrading or training? Yes No

Have you been unemployed for the past seven (7) consecutive days prior to this application? Yes No

Have you been available for work during the seven (7) consecutive days prior to this application? Yes No

Are you a Dislocated Worker? Yes No

Do you receive Public Assistance? Yes No If yes, which one? _____ (provide documentation)

Have you received a bona fide lay-off notice in the last six (6) months or will you be receiving one in the next six (6) months? Yes No

WORK HISTORY

19. Describe the last three (3) jobs held **starting with the most recent position**. Include military service and any volunteer work.

JOB 1	Start date (m/d/y)	End date(m/d/y)	Employer (Name and Address)
Hourly wage:	Hours per week:	Job Title:	Reason for leaving:
JOB 2	Start date (m/d/y)	End date(m/d/y)	Employer (Name and Address)
Hourly wage:	Hours per week:	Job Title:	Reason for leaving:
JOB 3	Start date (m/d/y)	End date(m/d/y)	Employer (Name and Address)
Hourly wage:	Hours per week:	Job Title:	Reason for leaving:

EDUCATION

Did you graduate from high school? Yes No If NO, did you receive a GED? Yes No

Last Grade completed? (Circle one) K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Are you in school/Vo-tech/college now? Yes No If yes, which one? _____

Are you scheduled to return to school? Yes No If yes, which one: _____

Schools attended or currently attending.

Type of School	School (Name and Location)	Dates Attended		Specify degree, diploma, license, or certificate received
		From (M/Y)	To (M/Y)	
General High School				
Technical/Vocational				
College/University				
Other				

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Name: _____

MARITAL STATUS: (circle one)

Single Married Divorced Widowed Common Law Separated

List the name(s) of all family members **including yourself**, residing with you, and their income for past 3 and 6 months.

a. Family Member	b. Age	c. Relationship	d. All sources of income	e. Income past 3 mos.	f. Income past 6 mos.
SELF		SELF			

AIC USE ONLY:

Family Size Last Six months	Total		\$	\$
	Total Annualized		\$	\$

Have you been or currently in a Workforce Center program? Yes No If yes, complete (a) through (e).

(a) Sponsoring Organization	(b) City	(c) State	(d) Contact person / Phone Number	(e) Date of Participation (M/D/Y)	
				From	To

BARRIERS TO EMPLOYMENT

Are you female/male age 22 or less with dependent children? Yes No
 Have you been arrested or convicted of a felony? Yes No If yes, please explain: _____
 Have you ever been or are currently being treated for substance abuse? Yes No If yes, please explain: _____
 Are you residing in a prison, hospital or other institution or facility providing 24-hour support? Yes No
 If yes, Type of facility: _____ Location: _____
 Are you a regular out patient of a mental hospital, rehabilitation facility or similar institution? Yes No
 If yes, type of facility: _____ Location: _____

NEPOTISM

Are any of your immediate relatives employed with AIC (Arkansas)? Yes No
 If yes, indicate name and relationship to you? _____

CERTIFICATION:

I certify that the information is true to the best of my knowledge. I am also aware that the information I have provided is subject to review and verification and I may have to provide documents to support this application. I am also aware that I am subject to immediate termination if I am found ineligible after enrollment and may be prosecuted for fraud and/or perjury. I allow release of this information for verification purposes and understand that it may be used to determine eligibility.

Signature of Applicant: _____ Date: _____
 Type your name as your signature

EMPLOYMENT/UNEMPLOYMENT VERIFICATION FORM

(Complete Part I or II whichever applies to your situation)

Part I

I, _____ confirmed that _____
Employment HR/Personnel Representative Client Name

() is **currently employed** with _____ working _____ hours per
week and has been since _____.
Date

OR

() **was employed** with _____ and ended employment
Company
with company on _____.
Date

Signed: _____ Date: _____
Type your name as your signature

Title: _____

Part II

Date _____

Name: _____ DOB: _____

() I certify that my last date of employment was _____ at _____
Date Company

and I am unable to provide proof of unemployment either with a signed statement above or
through the Employment Security Division.

() I certify that I have never been in the workforce.

Signature _____ Date: _____
Type your name as your signature

Official Use Only:

Notes:

Veteran's Priority of Service Screening Form

American Indian Center of Arkansas
400 W. Capitol, Ste 1611
Little Rock, AR 72201
501-666-9032/800-441-4513 Fax: 501-666-5875

Name _____

If you think you may qualify to receive Veteran's Priority of Service please complete this form and place it in the designated collection point at the reception desk so we can determine how best to serve you.

Veterans' Priority of Service Definitions — You must meet at least one definition below to qualify:

Veteran: A person who served in the active military, naval or air service, and who was discharged or released there from under conditions other than dishonorable. Active service includes full-time duty in the National Guard or a Reserve component, other than full-time duty for training programs.

Spouse: A spouse of any one of the following individuals:

1. Any veteran who died of a service-connected disability;
2. Any member of the armed forces serving on active duty who, at the time of application for the priority, is listed in one or more of the following categories and has been listed for a total of more than 90 days:
 - A. Missing in action;
 - B. Captured in line of duty by a hostile force; or
 - C. Forcibly detained or interned in the line of duty by a foreign government or power;
3. Any veteran who has a total disability resulting from a service-connected disability, as evaluated by the Department of Veterans Affairs; or
4. Any veteran who died and a total disability (service connected), as evaluated by the Department of Veteran Affairs was in existence.

Are you a Veteran? YES NO

Are you married to a Veteran? YES NO

Are you the surviving spouse of a Veteran? YES NO

Note: If you answered "yes" to any of the questions above, you may qualify to receive Veterans' Priority of Service.

PLEASE PROVIDE OFFICIAL NOTICE ISSUED BY A STATE VETERANS' AGENCY THAT DOCUMENTS VETERAN STATUS OR SPOUSAL RIGHTS.

Equal Opportunity Employer/Program. Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office manager TTY/TDD Services: 7-1-1

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RELEASE OF INFORMATION

Professional ethics and the WORKFORCE INNOVATIONS and OPPORTUNITIES ACT (WIOA) regulations prohibit the exchange of information concerning an individual without the written permission of the individual involved.

I, _____, am applying for services from the American Indian Center of Arkansas through the WIOA programs. I am fully aware that verification of information is required to determine my eligibility for participation in this program and to track my progress.

I hereby authorize and direct the organizations listed below to release information to the American Indian Center of Arkansas starting with the date of application and ending eighteen months after the date of exit from WIOA programs.

I further authorize the American Indian Center of Arkansas to share information with the organizations listed below to facilitate my participation in WIOA programs.

Signature of Applicant (type name as signature)

Date

The organizations that may be asked to release information include:

- Training Providers
- Public/Private Education Institutions
- Selective Services
- Social Security Administration
- Counseling Agencies
- Tribal Offices
- Past, Present and Potential Employers
- Department of Labor
- Other: _____

The American Indian Center of Arkansas will only solicit information that is necessary and relevant to program operations and will treat such information as confidential. Information will not be released to any unauthorized person, organization or agency.