Comanche Nation Workforce (W.I.O.A.)

Native Employment Works (N.E.W.) Application

Federal

The Comanche Nation NEW Program is grant funding supplemented on the federal level and made available to members of federally recognized tribes. Clients must reside within Southwestern Oklahoma which include: Comanche, Cotton, Caddo, Kiowa, and Tillman counties. Services will be provided to clients who are TANF recipients, Single Head of Household with Dependents under 18 years of age, and/or meet the Department of Health & Human Services Poverty Guidelines. Services provided once (1) per year.

Please Understand: All of these Documents are required before your application will be accepted. We will not hold incomplete applications.

⇒ Picture Identification
⇒ CDIB Card/Letter
⇒ Social Security Card (or a federally recognized tribal seal certified letter or card w/ SS# on it)
⇒ Proof of Income (for ALL household family members working)
⇒ Proof of Residency (personal mail, utility bill, rent receipt, etc.)
⇒ Proof of Public Assistance (TANF, Food Stamps, etc.), if applicable
⇒ Proof of High School Diploma, GED or College Transcript (if applicable)

COMANCHE NATION WORKFORCE
"WHERE BUSINESS AND OPPORTUNITIES MEET."

Revised: 1/24/20

COMANCHE NATION
WORKFORCE
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COVID-19 Liability Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC, WHO, and many other public health authorities still recommend practicing social distancing.

I further acknowledge that the Comanche Nation Tribe, Tribal Headquarters, Tribal Entities, Tribal Departments, and Tribal Programs have put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that the Comanche Nation Tribe cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, tribal employees, and other tribal clients and their families.

I voluntarily seek services provided by the Comanche Nation Tribe and the Comanche Nation Workforce Department and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures and guidelines to reduce the spread while completing my employability training at various worksites.

I attest that:

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I have not traveled internationally within the last 14 days.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
* I am following all CDC & WHO recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

Revised & Updated: 6/26/2020

"I hereby release and agree to hold the Comanche Nation Tribe, Comanche Nation Tribal Employees, and the Comanche Nation Workforce Department harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the tribe, or that may otherwise arise in any way in connection with any services received from the Comanche Nation Tribe and Comanche Nation Workforce Department."

"I understand that this release discharges the Comanche Nation Tribe and Comanche Nation Workforce Department from any liability or claim that I, my heirs, or any personal representatives may have against the tribe with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from the Comanche Nation Tribe and/or Comanche Nation Workforce Department. This liability waiver and release extends to the tribe together with all departments, programs, entities, owners, partners, and employees."

Print Name: _____

Signature: _____ Date: _____

OFFICE USE ONLY:

_____

Workforce Staff Signature (Witness) Date

_____

Workforce Director Signature (Acknowledgment) Date

Contact Information:
1608 SW 9th St.
Lawton, OK 73505
580-492-3257
www.comanchenation.com

Revised & Updated: 6/26/2020

Comanche Nation Workforce (W.I.O.A.)
Mailing: P.O. Box 908/Physical: 1608 SW 9th St.
LAWTON, OK 73502 LAWTON, OK 73501
Office: (580) 492-3257
Fax: (580) 492-3770

N.E.W. INTAKE RECORD REV 1/20/2021

1 DATE & TIME OF INTAKE

2 SOCIAL SECURITY NO. ---- ----

3 GENDER (Circle One) MALE FEMALE

4 BIRTHDAY

5 AGE

6 LAST NAME FIRST MIDDLE

7 TELEPHONE NO. ( ) --

8 MARITAL STATUS (circle one)
1. Single
2. Married
3. Divorced
4. Widowed
5. Separated
6. Common law

9 EDUCATIONAL STATUS (circle one)
1. In School, H.S. or less
2. In-School, Post H.S.
3. Not attending school, H.S. Graduate
4. Not attending school, H.S. Dropout
5. Other _____

10 SCHOOL ATTENDANCE (circle one)
1. Full-Time
2. Part-Time
3. Not Attending school

11 TYPE OF SCHOOL (circle one)
1. Elementary
2. Secondary
3. Trade/Tech/Voc.
4. Jr/Community College
5. Four Year University
6. Not Applicable

12 Last Grade Completed

13 PRESENT EMPLOYMENT STATUS (CIRCLE ONE)

1.Employed
A. Full-Time
B. Part-Time
C. Underemployed
D. In need of services to be Self-Sufficient

2.Employed but received termination of employment or military separation

3.Not employed, was employment sought within the last 28 days? [No] [Yes]
LAST DAY WORKED ___/___/___

14 STREET ADDRESS (*Residence*) ZIP CODE

CITY STATE

MAILING ADDRESS (*IF DIFFERENT FROM RESIDENCE*) CITY STATE ZIP CODE

15 U.S CITIZENSHIP (circle one)
1. Citizen
2. Eligible Non-Citizen
3. Non-Eligible Non-citizen

16 CULTURAL IDENTIFICATION (circle one)
1. American Indian
2. Alaskan Native
3. Native Hawaiian

17 TRIBAL MEMBERSHIP (circle one)
1. Yes - Tribal Affiliation: _____
Tribal Enrollment #: _____
2. No
3. Not Known

E-mail Address:
_____@_____

18 VETERANS PREFERENCE (circle one)
1. Less than or equal to 180 days
2. Eligible Veteran
3. Other Eligible Person
4. Not a Veteran

19 SELECTIVE SERVICE REGISTRATION (circle one)
1. Yes
2. No
3. Exempt
4. Not Required to Register (Under 18, Female, etc.)

20 PUBLIC ASSISTANCE (circle ALL that apply)
1. GA/BIA
2. TANF
3. SSI/SSA/SSDI
4. Food Stamps
5. Foster Child Payments
6. TWEP
7. Food Commodities
8. Veteran Benefits
9. None

21 Family Income Level (circle all that apply)
1. At or below HHS
2. At or below 70% of LLSIL
3. Above HHS
4. Above 70% of LLSIL

22 BARRIERS TO EMPLOYMENT(circle all that apply)
1. Basic Skills Deficient
2. Low Income
3. Unemployed 6+ Mo.
4. Offender/Criminal Justice
5. Single Head Of Household
6. Pregnant/Parenting Teen
7. Limited English Proficiency
8. Individual with Disability
9. Poor Work History
10. Underemployed
11. Homeless
12. Displaced Homemaker
13. School Drop-Out
14. Runaway
15. Youth Additional Asst.
16. Welfare Recipient
17. Learning Disability
18. Not Applicable

23 EMPLOYMENT HISTORY (Last 6 Months or Over – Current/Last Job First)
(Enter the employer's name, address, zip code and telephone number)

FROM Mo/Day/Yr	TO Mo/Day/Yr	JOB TITLE	HOURLY WAGE	HOURS PER WEEK	REASON FOR LEAVING

24 DO YOU HAVE IMMEDIATE FAMILY MEMBERS EMPLOYED WITH THE COMANCHE NATION? IF SO, PLEASE INDICATE: No Family Members Employed: _____

NAME:_____ RELATIONSHIP : ( ) Mother ( ) Father ( ) Sister ( ) Brother ( ) Son ( ) Daughter ( ) Spouse

NAME:_____ RELATIONSHIP : ( ) Mother ( ) Father ( ) Sister ( ) Brother ( ) Son ( ) Daughter ( ) Spouse

25 PROGRAM PARTICIPATION (please check): ( ) New Applicant ( )Returning Applicant
If returning applicant, what service was provided and what year did you apply? ( ) WE ( ) CRT ( ) SS ( ) EE ( ) SYEP ( ) OJT Year: _____

Are you a former Comanche Nation Tribal Employee? ( ) Yes ( ) No If yes, please provide date of separation: _____

26 FAMILY MEMBERS – List the name(s) of all the applicant's family member(s) **LIVING** in the home and their relationship.

NAME	RELATIONSHIP
1.	SELF
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

27 FAMILY INCOME: LIST THE FAMILY	RELATIONSHIP	INCOME SOURCE	INCOME LAST LAST 6 MONTHS
1.	SELF		$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
TOTAL INCOME FOR THE LAST 6 MONTHS			$
			$ X2
FAMILY SIZE IN THE LAST 6 MONTHS		TOTAL ANNUALIZED FAMILY INCOME	$

28 Family Size	Poverty Guidelines
1	$12,880
2	$17,420
3	$21,960
4	$26,500
5	$31,040
6	$35,580
7	$40,120
8	$44,660

Complete if more than 8 people in family.

Family Size	HHS Guidelines	70%LLSIL Non-Metro

29 CERTIFICATION STATEMENT:

I certify that the information provided is true and complete to the best of my knowledge and that there is no intent to commit fraud. I am aware that the information I have provided will be used to determine eligibility for program services and is subject to review and verification and that I may have to provide documents to support this intake. It has been explained to me and I understand that:

(1) Information collected on the Intake Record will be entered and stored in the Comanche Nation Workforce Grant Performance Management System located at the CN Workforce Office at 1608 SW 9th St., Lawton, Oklahoma. All or part of the information provided may be shared with the Department of Labor for program performance measurements. I also understand that the information recorded on the Intake Record will be protected in accordance with the Privacy Act.

(2) Misstatements or misrepresentations on my part in these or other related forms may be cause for dismissal and possible actions for the collection of any payments received by me. Anyone who makes a false statement or misrepresentation of facts in an application for determination of program eligibility may be committing a crime punishable by law and may be fined or put in jail for fraud and/or perjury.

(3) Should I be deemed ineligible for Workforce Development by the official verification process, I agree to immediately relinquish Workforce Development funded employment training and I may be liable for all payments made to me and on my behalf while enrolled in the Workforce Development program.

I hereby authorize the sharing of this information with other CNW programs and their partner agencies if needed.
I further understand that eligibility is not a guarantee of program services.

30 ELIGIBLE FUNDING (circle ALL THAT APPLY)
1. CNG
2. WIOA - Adult
3. WIOA - Youth
4. NEW
5. INELIGIBLE

31		
APPLICANT SIGNATURE:		DATE:
PARENT/GUARDIAN SIGNATURE **(IF APPLICANT IS UNDER 18)**:		DATE:
INTERVIEWER SIGNATURE:		DATE:

32 CERTIFICATION OF PROGRAM ELIBIBILITY (circle all that apply)
1. WE 2. CRT 3. SS 4. EE 5. SYEP 6. OJT 7. INELIGIBLE

CERTIFIER SIGNATURE:	DATE:
REVIEWER SIGNATURE:	DATE:

AUTHORIZATION TO RELEASE INFORMATION

I, _____, **authorize** the release of my personal and/or business-related information for employment verification purposes and/or program assistance to the named department/program listed below:

Name: Comanche Nation Workforce

Address: P.O. Box 908

City: Lawton State: OK Zip Code: 73502

Fax: 580-492-3770

This request and authorization also apply to and/or release of: (check all that apply)

☐ Tribal Related Records
☐ Employment Records
☐ Copies of Personal Information
☐ Education Records
☐ Financial Records
☐ Public Assistance Information

☐ Other: (Please list any other items not specified above)

_____

I, _____, **do not authorize** the release of my personal and/or business-related information to any department, program, organization, and/or business of any kind.

Applicant Signature: _____ Date Signed: _____

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Revised & Updated: 3/15/2021

Comanche Nation Workforce (W.I.O.A.) Department

N.E.W. Program (Federal): Individual Plan of Service (IPS)

Applicant Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Mailing Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Tribal Enrollment No.: _____ Social Security No.: _____ Date of Birth: _____

Program Applying For (circle one):

Work Experience (WE) Supportive Service (SS) Classroom Training (CRT)

Service Requested (circle **one** pertaining to the program):

Work Attire (SS/WE/CRT) Work Tools (SS) Car Repairs (SS/WE) License Reinstatement (SS)

Occupational License Renewal (SS/CRT) Public Transportation (WE/SS/CRT)

Client Signature: _____ **Date:** _____

By completing this form, you are requesting services from the Native Employment Works (NEW) program and depending on your current situation and/or current employability, you could qualify for the service. Please keep in mind that current NEW Poverty Guidelines will be enforced and followed.

OFFICE USE ONLY:

Funding Source: NEW 1617

Amount Specified: _____

RQ Date: _____ **RQ #:** _____ **Line Item:** _____

If an SS, make payable to (optional): _____

Workforce Service Provider Signature: _____ **Date:** _____

Workforce Director Signature (Approval): _____ **Date:** _____