



# Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No. 1615-0047

Expires 05/31/2027

**START HERE:** Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**Section 1. Employee Information and Attestation:** Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number (if any)	City or Town	State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address		Employee's Telephone Number
<b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): <input type="checkbox"/> 1. A citizen of the United States <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) <input type="checkbox"/> 4. An alien authorized to work until _____ (exp. date, if any)		
Signature of Employee		Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the **Preparer and/or Translator Certification on Page 3**.

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.		
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.				First Day of Employment (mm/dd/yyyy):	
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative			Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete **Supplement B, Reverification and Rehire on Page 4**.

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

**Examples of many of these documents appear in the Handbook for Employers (M-274).**

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions:
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		(1) NOT VALID FOR EMPLOYMENT
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:		5. U.S. Military card or draft record		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
a. Foreign passport; and		6. Military dependent's ID card		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
b. Form I-94 or Form I-94A that has the following:		7. U.S. Coast Guard Merchant Mariner Card		4. Native American tribal document
(1) The same name as the passport; and		8. Native American tribal document		5. U.S. Citizen ID Card (Form I-197)
(2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		9. Driver's license issued by a Canadian government authority		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		<b>For persons under age 18 who are unable to present a document listed above:</b>		7. Employment authorization document issued by the Department of Homeland Security
		10. School record or report card		For examples, see <u>Section 7</u> and <u>Section 13</u> of the M-274 on <a href="http://uscis.gov/i-9-central">uscis.gov/i-9-central</a> .
		11. Clinic, doctor, or hospital record		The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.
		12. Day-care or nursery school record		

### Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> <li>Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>
--	----	---	---

\*Refer to the Employment Authorization Extensions page on [I-9 Central](http://I-9 Central) for more information.

## GENERAL INFORMATION OF PARTICIPANT

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Last Name

First Name

MI

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

Current Address

City

State

Zip

Home Telephone: \_\_\_\_\_

Mobile Telephone: \_\_\_\_\_

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Last 4 digits of Social Security Number

<input type="text"/>
----------------------

Date of Birth

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Alternate Contact Name

Telephone Number

## DEMOGRAPHIC INFORMATION – Workforce Development (CDBG-DR 2018)

(for evaluation of equitable distribution of funds)<sup>6</sup>

### Race and Ethnicity

#### **Ethnicity: (select only one)**

Hispanic or Latino

Not Hispanic or Latino

#### **Race: (select one or more)**

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

### Marital Status

Single

Married

Widowed

Divorced

Separated

Other

### Gender

Male

Female

---

<sup>6</sup> The race/ethnicity/gender information is requested by the Federal Government for certain federally supported programs to monitor compliance with equal opportunity laws. You are not required to furnish this information (race/ethnicity/gender) but are encouraged to do so. The law provides that a provider may not discriminate either based on this information, or on whether you choose to furnish it.

## **DISCLOSURE OF INCOME FOR PARTICIPANT**

Any items indicated by "yes", attach related documentation.

**Do you receive periodic income, such as:**

Yes      No

- a. Retirement funds.....
- b. Pension.....
- c. Social Security Benefits.....
- d. Supplemental Security Income (SSI).....
- e. Annuities.....
- f. Insurance Policies.....
- g. Disability or Death Benefits.....
- h. TANF.....
- i. Unemployment Benefits.....
- j. Workmen's Compensation.....
- k. Child Support/Alimony.....
- l. Military.....
- m. Taxable Asset Income .....
- n. Other Income.....

**Are you receiving income from:**

- a. Employment.....
- b. Self-Employment.....

  


## **Do you have any of the following potential asset income:**

- a. Checking Account.....
- b. Savings Account.....
- c. CD (Certificate of Deposit Account) .....
- d. IRA or other Retirement Account (i.e., 401k, 457) .....

**Do you regularly receive monetary gifts or non-cash contributions from persons outside your household for<sup>2</sup>:**

- a. Mortgage, Rent, Living Expenses.....
- b. Utilities.....
- c. Groceries.....
- d. Clothing.....
- e. Miscellaneous.....

A vertical stack of five empty rectangular boxes, each with a black border, intended for handwritten responses.

I certify that I have answered truthfully to the best of my knowledge. I further understand that submittal of false information is punishable under Federal Law. I have no objections to inquiries being made to verify any information listed above.

---

**Participant Signature**

\_\_\_\_\_

Date

<sup>2</sup> For items in this section indicated "yes", attach the Verification of Recurring Contributions form

**DISCLOSURE OF INCOME FOR OTHER ADULT HOUSEHOLD MEMBER(S)<sup>3</sup>**

**Do you receive periodic income, such as:**

a. Retirement funds.....	_____
b. Pension.....	_____
c. Social Security Benefits.....	_____
d. Supplemental Security Income (SSI).....	_____
e. Annuities.....	_____
f. Insurance Policies.....	_____
g. Disability or Death Benefits.....	_____
h. TANF.....	_____
i. Unemployment Benefits.....	_____
j. Workmen's Compensation.....	_____
k. Child Support/Alimony.....	_____
l. Military.....	_____
m. Taxable Asset Income .....	_____
n. Other Income.....	_____

### **Do you receive periodic income, such as?**

a. Employment.....    
b. Self-Employment.....

### **Do you have any of the following:**

- a. Checking Account.....
- b. Savings Account.....
- c. CD (Certificate of Deposit Account) .....
- d. IRA or other Retirement Account (i.e., 401k, 457) ....

**Do you regularly receive monetary gifts or non-cash contributions from persons outside your household for:**

a. Mortgage, Rent, Living Expenses.....	_____	_____
b. Utilities.....	_____	_____
c. Groceries.....	_____	_____
d. Clothing.....	_____	_____
e. Miscellaneous.....	_____	_____

I certify that I have answered truthfully to the best of my knowledge. I further understand that submittal of false information is punishable under Federal Law. I have no objections to inquiries being made to verify any information listed above.

---

#### Non-participant adult household member

Date

<sup>3</sup> \*Complete additional forms for each adult member, as applicable

## HOUSEHOLD<sup>4</sup> COMPOSITION CERTIFICATION<sup>5</sup>

As of \_\_\_\_\_ (date of application), I, \_\_\_\_\_ resided at: (property address) \_\_\_\_\_

**Circle the correct response:**

- 1) At the time of time of the application I was living alone, **or** I expect to be living alone within the next 12 months.
- 2) The following people live with me and will continue to do so for the foreseeable future:

Name	Last 4 digits of SSN#	Date of Birth	Enrolled in School?

Do you expect your household composition to change in the next 12 months? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

## CONFLICT OF INTEREST CERTIFICATION

Do you, or anyone in your household, have family or business ties to anyone who assisted in the development or operations of the workforce development program?

**Circle one:**      Yes      No

If yes, describe the relationship and role:

<sup>4</sup> "Household" is defined as all persons occupying a housing unit. The occupants may be a family, as defined in 24 CFR 5.403; two or more families living together; or any other group of related or unrelated persons who share living arrangements, regardless of actual or perceived, sexual orientation, gender identity, or marital status. (24 CFR 570.3). Note: An applicant may be considered a smaller "household" than their current actual "household" number if the living situation is temporary or transitional, i.e., aging out of foster care, temporarily homeless and formerly incarcerated are examples of individuals that may be temporarily part of a larger household than what would be considered in a "household calculation".

<sup>5</sup> Complete one form for each applicant household

## **CERTIFICATION OF HOUSEHOLD INFORMATION AND INCOME**

(To be completed by participant and other adults of household, if applicable)

---

---

I (We), \_\_\_\_\_ (and) \_\_\_\_\_ do hereby certify that my (our) household consists of \_\_\_\_\_ members. I (We) certify that my (our) yearly income is \_\_\_\_\_. I (We) also certify that all the information that I (we) have given is correct to the best of my (our) knowledge.

---

Participant Signature

---

Date

---

Other Adult Household Signature

---

Date

7

## **HUD-COMMUNITY DEVELOPMENT BLOCK GRANT-DISASTER RECOVERY PROGRAM EQUAL OPPORTUNITY IS THE LAW**

It is against the law for this recipient of Federal financial assistance to discriminate on the following basis: Against any individual in the United States, on the basis of race, color, religion, sex (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity); national origin (including limited English proficiency); age; disability; political affiliation or belief; or against any beneficiary of, applicant to, or participant in, programs financially assisted under HUD-CDBG-DR program on the basis of the individual's citizenship status or 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 CDBG-DR 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. Recipients of federal financial assistance must take reasonable steps to ensure that communications with individuals with disabilities are as effective as communications with others. This means that, upon request and at no cost to the individual, recipients are required to provide appropriate auxiliary aids, and services to qualified individuals with disabilities

### **WHAT TO DO IF YOU BELIEVE YOU HAVE EXPERIENCED DISCRIMINATION**

If you think that you have been subjected to discrimination under a HUD-CDBG DR-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 the person whom the recipient has designated for this purpose); or the **Office of Departmental Equal Employment Opportunity Office (ODEEO)** or [EEO@hud.gov](mailto:EEO@hud.gov) or telephone number (202) 708-5921, or electronically as directed on [https://www.hud.gov/program offices/eeo](https://www.hud.gov/program_offices/eeo) within **45 calendar days** of the alleged discriminatory event or within **45 calendar days** of becoming aware of the alleged discriminatory event.

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 ODEEO.

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 may file a complaint with ODEEO before receiving that notice. However, you must file your ODEEO 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 ODEEO. You must file your ODEEO complaint within 30 days of the date on which you received the Notice of Final Action.

#### **FOR INFORMATION OR TO FILE A COMPLAINT, CONTACT**

**Marci Dillon, EQUAL OPPORTUNITY OFFICER**  
[Marcidillon@careerteam.com](mailto:Marcidillon@careerteam.com)  
Career Team, LLC.  
250 State Street, Suite C-2, North Haven, CT 06473  
203.407.8800

Effective Date: This notice is effective immediately and will remain in effect until further notice

I certify that I have been afforded an opportunity to discuss the "EQUAL OPPORTUNITY IS THE LAW" notice with a CDBG-DR representative. Please be advised. Information you provide to the CDBG-DR program may be made available to the Federal, State or Local agencies and their subcontractors who administer employment and training programs.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Auxiliary aids and services are available upon request to individuals with disabilities.

Equal Opportunity Employer Program

TTY No: 1(800) 735-2922

## **SUMMARY OF RIGHTS AND PROGRAM GRIEVANCE/COMPLAINT PROCEDURES**

Career Team, LLC. recognizes each individual's right to receive fair and impartial treatment under all of its services. As such, Career Team, LLC. encourages and supports a model of open communication and resolution at all program levels.

### **RIGHTS**

Participants, applicants, sub-grantees, subcontractors and employees have the right to file a non-criminal complaint with regards to HUD-Community Development Block Grant- Disaster Recovery (CDBG-DR) program activities. All persons filing a grievance or complaint shall be free from restraint, coercion, reprisal, or discrimination. You have the right to receive technical assistance in filing the grievance/complaint. You will not be punished in any way for filing a grievance/complaint.

### **FILING A GRIEVANCE/COMPLAINT**

Grievances or complaints must be filed **within one year** of the alleged violation. All grievances or complaints, amendments and withdrawals must be in writing, signed, and dated. Your written grievance/complaint must include, at a minimum, the following:

- 1) Your full name, telephone number, and mailing address;
- 2) The full name, telephone number, and mailing address of the agency or party you are complaining against;
- 3) A clear and concise statement of the facts and dates describing the alleged violation;
- 4) The provision(s) of CDBG-DR, federal regulations, grant, or other agreements under WIOA believed to have been violated;
- 5) If a grievance or complaint is against an individual, it shall indicate how those individuals did not comply with WIOA law, regulation, or contract.

Your written, signed, and dated grievance/complaint must be mailed to:

Christopher Caillouette, Executive Director  
Career Team, LLC.  
2901 N. Ventura Road, 3rd Floor  
Oxnard, CA 93036

Upon filing the grievance/complaint, you may be notified of the opportunity for an informal resolution. In the event of resolution or impasse, you must provide a written withdrawal of the complaint **within 10 days** of receipt of the notice of resolution or impasse. Hearings on any grievance or complaint shall be conducted **within 30 days** of the filing date of the grievance or complaint. You will be notified, in writing, of the hearing **at least 10 days** prior to the date of the hearing.

### **DECISION**

The hearing officer shall provide a written decision to the Workforce Development Board of Ventura County (WDBVC). The WDBVC shall mail the written decision to both parties by first class mail no later than **60 days** after the filing date of the grievance or complaint. If a complainant does not receive a decision within **60 days** of the filing date of the grievance or complaint, or receives an adverse decision, the complainant has the right to file an appeal with the state.

### **STATE LEVEL**

Appeals must be filed or postmarked **within 10 days** from the date on which the complainant received an adverse decision from the WDBVC. Requests for state review must be filed or postmarked **within 15 days** from either of the following:

- The date on which a complainant should have received a decision regarding a locally filed complainant, which is defined as five days from the date the decision was due.
- The date on which an instance of restraint, coercion, or reprisal was alleged to have occurred as a result of filing the complaint.

Complainants must submit appeals or requests for state review to the following address:

Chief, Compliance Review Office, MIC 22-M  
Employment Development Department  
P.O. Box 826880  
Sacramento, CA 94280-0001

## SUMMARY OF RIGHTS AND PROGRAM GRIEVANCE/COMPLAINT PROCEDURES (CONTINUED)

The state shall review the grievance or complaint and notify the complainant and respondent of the opportunity for an informal resolution **within 10 days** of receipt. State hearings on any grievance or complaint shall be conducted **within 30 days** of the filing of the grievance or complaint. You will be notified in writing of the hearing **at least 10 days** prior to the hearing.

Following completion of the state hearing, the state hearing officer shall make a written recommendation to the State Review Panel. The State Review Panel shall issue a decision on the basis of the information contained within the record. The State Review Panel may accept, reject, or modify the state hearing officer's recommendation or the decision of the WDBVC, and shall issue a written decision to the concerned parties **within 60 days** of the state's receipt of the WDBVC appeal, request for state review, or grievance or complaint.

### FEDERAL LEVEL

If the State Review Panel has issued an adverse decision regarding a grievance or complaint, or has not issued a decision **within 60 days** of receipt of a local level appeal, request for state review, or grievance or complaint, the complainant may file an appeal with the Secretary of Labor. This appeal process applies to grievances and complaints that originated at the local or state level.

Appeals of an adverse decision must be filed **within 60 days** of receipt of the adverse decision from the State Review Panel. In cases where the State Review Panel did not issue a decision, the complainant must file an appeal **within 120 days** of either of the following:

- The date on which the complainant filed the appeal of a local level decision or request for state review.
- The date on which the complainant filed the grievance or complaint with the state.

All appeals to the Secretary of Labor must be sent to the Department of Labor (DOL) National Office via certified mail with return receipts requested. Copies of the appeal must simultaneously be provided to the DOL Employment and Training Administration (ETA) Regional Administrator and the respondent. Mailing addresses for the DOL National Office and ETA Regional Administrator are included below:

#### DOL National Office

Secretary of Labor  
Attn: Assistant Secretary of ETA  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

#### ETA Regional Administrator

Office of Regional Administrator  
U.S. Department of Labor  
P.O. Box 193767  
San Francisco, CA 94119-3767

The Secretary shall issue a final determination no later than **120 days** after receiving the appeal.

These procedures provide for resolution of complaints alleging a violation of WIOA regulations as promulgated under either Act, recipient grants, subagreements or other specific agreements under either Act, including terms and conditions of participant employment; and resolution of complaints arising from actions, such as audit disallowances or the imposition of sanctions taken by the governor with respect to audit findings, investigations or monitoring reports. All complaints will be handled confidentially.

I understand these procedures as explained by Staff. A copy of these procedures has been provided to me.

---

Read and Acknowledged by

---

Date

---

Parent/Guardian Signature (if applicable)

---

Date

This WIOA Title I-financially assisted program or activity is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities.

## CONFLICT OF INTEREST STATEMENT

No individual receiving CDBG-DR funding or services can be directly supervised by a member of his/her immediate family\*, who is employed by the County of Ventura.

Additionally, no individual receiving CDBG-DR funding or services can be directly supervised by a member of his/her immediate family\*, who is an employee in a CDBG funded training program.

It is critical, under both circumstances, that Ventura County employees and subcontractors avoid conflict of interest and/or the appearance of a conflict of interest in the management of CDBG-DR funds.

Note: Answering yes to either question does not affect eligibility to participate in CDBG-DR program.

Please answer the following questions:

1) Are you related to anyone by blood, marriage, or adoption, who works for Career Team?

Yes       No

If yes, please list:

Name: \_\_\_\_\_  
Department: \_\_\_\_\_

Relationship: \_\_\_\_\_  
Position: \_\_\_\_\_

2) Are you related to anyone by blood, marriage, or adoption, who is a staff person in your CDBG-DR funded training program?

Yes       No

If yes, please list:

Name: \_\_\_\_\_  
Department: \_\_\_\_\_

Relationship: \_\_\_\_\_  
Position: \_\_\_\_\_

\*Immediate family are individuals who are related by blood, marriage or adoption include the following relationships: wife, husband, son, daughter, mother, father, brother, brother-in-law, sister, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, aunt, uncle, niece, nephew, step-parent and step-children.

---

Customer Name

---

Customer Signature

---

Date

56-21-103 (01/2025)

## DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

## DIVISION OF FINANCIAL ASSISTANCE

2020 W. El Camino Avenue, Suite 670, 95833  
 P.O. Box 952054 Sacramento, CA 94252-2054



## Authorization to Share and Release Information

Purpose: Consent to allow California Department of Housing and Community Development (HCD) and/or a Workforce Development Program to request information from 3<sup>rd</sup> parties to verify an applicant's eligibility. Moreover, a signed form grants permission for HCD to release applicants' demographic information to HUD in aggregate form.

I, \_\_\_\_\_, authorize the following agencies collaborating in the CDBG-DR 18 Workforce Development Program to collect information relevant to my eligibility to participate in the Program.

Department of Housing and Community Development	Career Team, LLC.
2020 W. El Camino Avenue, Suite 670, Sacramento, CA 95833	2901 N. Ventura Road, 3rd Floor Oxnard, CA 93036
(916) 263-7400	(805) 648-9675 or email: <a href="mailto:ventura@careerteam.com">ventura@careerteam.com</a>

The information that may be released includes, but is not limited to:

1. Information about my current employment status, wages and projected income
2. Information about recurring contributions
3. Information about my current household composition (who lives with me)
4. Information about my participation in other workforce development programs

I also permit representatives from the agencies/organization listed above, who are working with me or on my behalf, to discuss these matters specifically related to my participation in the Workforce Development Program.

I further permit these agencies to share my demographic data<sup>7</sup> (race, ethnicity, and gender) to HUD for the purposes of evaluating the Workforce Development Program and improving services.

My signature below indicates I have read this form and/or have had it read to me. I can revoke this consent in writing at any time.

Participant's name (printed) \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

<sup>7</sup> The race/ethnicity/gender information is requested by the Federal Government for certain federally supported programs to monitor compliance with equal opportunity laws. You are not required to furnish this information (race/ethnicity/gender) but are encouraged to do so. The law provides that a provider may not discriminate either based on this information, or on whether you choose to furnish it.

## **AUTHORIZATION TO RELEASE INFORMATION**

In compliance with the Family Education Rights and Privacy Act (FERPA), and the HUD-Community Development Block Grant-Disaster Recovery (CDBG-DR) Program, Career Team, LLC. is responsible for the maintenance of customer records and for monitoring release of information related to those records.

The America's Job Centers of Ventura County, staffed by representatives from partner agencies and organizations are responsible for the direct and indirect provisions of services set forth by WIOA. Staff from some or all of these agencies may need to access customer records to ensure the highest quality delivery of services to the Individual customer.

It is understood that the information shared between the CDBG-DR staff, and America's Job Center partner agencies is confidential in nature and is used solely for the purpose of providing high quality services to you, the customer. The information will not be released to entities other than those listed without express written consent of the customer.

It is further understood that records are to be maintained by WIOA staff, America's Job Center Staff, and partners in a confidential manner, away from access by non-personnel who may be in the center as a visitor, a customer and for any other purpose.

I, the undersigned, \_\_\_\_\_, authorize the release of information to the CDBG-DR Staff, contractors (if applicable) and within the America's Job Center system of Ventura County.

1. I release the power of confidentiality to contact past and/or future employers regarding hire date, starting / current pay, starting / position and all information that may / will pertain to job performance, placement and post-employment / follow-up services.
2. I hereby authorize and give permission to Employment Development Department to release base wage file records regarding my employment.
3. I hereby authorize and give permission to obtain and/or release information from my  
 Employer    Probation Officer    Other

I understand that this release is effective until the conclusion of WIOA program.

---

Customer \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

56-21-104 (07/19)

## **PARTICIPANT ORIENTATION/RESPONSIBILITY FORM**

Below are important topics that will be discussed with you before you enroll:

1. Introduction to the Ventura County Healthcare Employment Accelerator (VC HEAL) Program
2. Program Objectives
3. Eligibility Requirements
4. Verification of Eligibility
5. Rights - Civil Rights/EO, Grievance Procedures, Customer Choice
6. Benefits (one-on-one career coaching, job search assistance, etc.)
7. Responsibilities (active job search participation, submission of required documents – eligibility documents, training validation, etc.)
8. Length of participation
9. Compliance monitoring
10. Individual Training Accounts (ITA)
11. Individual counseling/vocational guidance
12. Validation of employment or employment verification (e.g. paystubs, signed employment verification, offer letter, etc.)
13. Validation of household income (e.g. tax returns, paystubs, etc.)
14. 12 months follow-up after exit

**I acknowledge that the staff has explained and reviewed the above program requirements and provisions to me.**

Participant Name/Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff: \_\_\_\_\_

Date: \_\_\_\_\_

## DISASTER RECOVERY BENEFITS COMPLIANCE

---

The workforce development program for which you are applying is funded in whole or part by Community Development Block Grant – Disaster Recovery funds related to the 2018 wildfire disasters in California. The following information is required to be collected for the program administrators to evaluate a potential Duplication of Benefits.

- 1) Are you currently receiving, or have you received in the last 3 years, any assistance for the purpose of workforce development training courses(s) you are currently applying for? (i.e., Pell Grants, Educational funds)

No  or Yes

If yes, If yes, please provide the name of the program, last date of receipt of funds, and amount:

---

- 2) Have you entered into or completed the same or similar course(s) – that you are applying for – within the last 3 years? (If the response is yes, additional conversations with HCD Program staff may be required.)

No  or Yes

I/We certify that I/We have been asked the above questions and they have been answered truthfully to the best of my/our knowledge. I/We further understand that submittal of false information is punishable under Federal Law. I/We have no objections to inquiries being made to verify any information listed above.

---

**Participant**

**Other adult household member**

For reviewer's comments only with respect to Duplication of Benefits and other compliance items indicated above:

For reviewer's comments only with respect to Duplication of Benefits and other compliance items indicated above:

### **Alternate Contact Information**

After you complete our program, we will want to keep in touch with you to see how you are progressing and to see if we can help. To do this, we need to have your current contact information on file. Also, please provide the names, telephone numbers and email addresses of two individuals who will know where to reach you in case you relocate.

**PLEASE PRINT YOUR:**

Full Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**PLEASE PRINT THE NAMES, TELEPHONE NUMBERS AND EMAIL ADDRESSES OF TWO (2) PERSONS WHO DO NOT LIVE WITH YOU, BUT WILL KNOW HOW TO CONTACT YOU IN CASE YOU RELOCATE:**

**ALTERNATE 1**

Name: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**ALTERNATE 2**

Name: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Dear Employer:

I have authorized Career Team, LLC. on behalf of the VC HEAL Program to secure the information requested below regarding my employment status with your company. Career Team, LLC. will be conducting follow-ups on my employment for a minimum of twelve (12) months after my completion from the program. This verification form is valid for up to three (3) years from the date below.

---

Customer Signature

---

Date

---

Printed Name

---

XXX-XX-

Social Security # (last four digits)

The above referenced person has participated in the program. To assist our program in closing the participant's file, we would appreciate the following information. All information will be kept confidential.

Please return this document by password protected email. If you have any questions, please contact [ventura@careerteam.com](mailto:ventura@careerteam.com) from 8 A.M. to 5 P.M. or by phone at: (805) 204-5186,

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Employment From: \_\_\_\_\_ To: \_\_\_\_\_

Job Title: \_\_\_\_\_

Hourly Wage: \_\_\_\_\_ Hours per Week: \_\_\_\_\_ Health Benefits: Yes or No

Verified by \_\_\_\_\_

Signature

Printed Name

Title \_\_\_\_\_ Date \_\_\_\_\_



Date: October 20, 2023

Re: Updated Beneficiary Self-Certification of Annual Income Form

**This cover page accompanies the minor change to the Beneficiary Self-Certification of Annual Income Form revised October 20, 2023.**

This updated form replaces the version currently in the Policies and Procedures Manual v3. Please discard the previous version and use the revised form dated 10/20/23 for all beneficiary income certifications moving forward.

*Updated Household demographics to reflect Family demographics, pages 1-2.*

*“Family” means one or more persons living in your household who are related by birth, marriage, or adoption. Number of persons in your family shall reflect all family members, including those temporarily away from the home (e.g., college students, persons on extended vacation, etc.).*

**Family Demographic Definitions:**

- *Female Head of Household is an adult member of the family who is a woman responsible for managing the household without a spouse.*
- *Senior Head of Household is an elderly family member, 62 years or older, responsible for managing the household. Note, a family could be both headed by a female and senior.*
- *Single Parent Family is a family with only one parent present in the home. The parent may be never married, widowed, divorced, married, or spouse absent.*

This updated form will be replaced in the Policies and Procedures Manual v4, to be released at a future date.



### BENEFICIARY SELF CERTIFICATION OF ANNUAL INCOME

**PURPOSE:**

VC Heal Healthcare Careers (CDBG-DR) is collecting the following information because of participating in the U.S. Housing and Urban Development's (HUD) Community Development Block Grant Disaster Recovery (CDBG-DR) Workforce Development Program.

To meet federal regulations, VC Heal Healthcare Careers (CDBG-DR) is required to collect statistical data on your family income, race/ethnicity, and family demographics. This information is reported to HUD and eventually used by the U.S. Congress to measure the effectiveness of the CDBG program. Your name and personal information will be kept private, and your income, race, and ethnicity information only shared with the federal government anonymously.

**INSTRUCTIONS:**

Applicants must complete the form and then sign and date the form certifying the information is correct. Your information can only be accepted if the required information is completed, signed, and dated.

**1. Please complete the following family demographic information.**

*"Family" means one or more persons living in your household who are related by birth, marriage, or adoption. Number of persons in your family shall reflect all family members, including those temporarily away from the home (e.g., college students, persons on extended vacation, etc.).*

Family Demographics	Yes	No	#
Female Head of Household:	<input type="checkbox"/>		N/A
Senior Head of Household:	<input type="checkbox"/>		N/A
Single Parent Family:	<input type="checkbox"/>		N/A
Family contains a person with disabilities:	<input type="checkbox"/>		N/A
How many in the family are elderly? (62 and over)	<input type="checkbox"/>	N/A	
How many in the family are adult full-time students? (18 and over)	N/A	N/A	
How many in the family are under the age of 18 years?	N/A	N/A	

**2. Please check the box that most closely identifies your race and ethnicity.**

*HCD understands that the choices listed in the box below do not include all of the ways in which people self-identify, and that many people identify with more than one of the categories listed. Applicant should check the box that most closely represents their racial identity. Race category definitions are provided on the last page.*

<input type="checkbox"/> White	<input type="checkbox"/> Black/African American and White
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian and White
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaskan Native and African American
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Other Multi-Racial
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Prefer Not Answer
<input type="checkbox"/> American Indian/Alaskan Native and White	

Do you consider yourself as being of Hispanic ethnicity?  Yes  No  Prefer Not to Answer



### BENEFICIARY INSTRUCTIONS FOR COMPLETING SELF CERTIFICATION OF ANNUAL INCOME FORM

#### 1. Family Demographic Information

Family demographic information is collected to satisfy HUD reporting requirements. The answers to these questions do not impact your eligibility to participate in the program.

- **Female Head of Household** is an adult member of the family who is a woman responsible for managing the household without a spouse.
- **Senior Head of Household** is an elderly family member, 62 years or older, responsible for managing the household. Note, a family could be both headed by a female and senior.
- **Single Parent Family** is a family with only one parent present in the home. The parent may be never married, widowed, divorced, married, or spouse absent.
- **Disabled Person** includes any (1) individual with a physical or mental impairment that substantially limits one or more major life activities; (2) individual with a record of such impairment; or (3) individual who is regarded as having such an impairment.

#### 2. Racial Identification

Racial and ethnic information is required for HUD data reporting purposes. The applicant should choose the race that they most closely identify with. The answers to these questions do not impact your eligibility to participate in the program.

Please refer to [2020 Census Frequently Asked Questions About Race and Ethnicity](#) for up to date racial and ethnicity information.

- **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. (*For example: German, Irish, English, Spanish, Italian, Lebanese, Egyptian, etc.*)
- **Black/African American:** A person having origins in any of the black racial groups of Africa. (*For example: Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.*)
- **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **American Indian/Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community attachment.
- **Native Hawaiian/Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **Prefer Not to Answer/ Unknown:** The category used to report students or employees whose race and ethnicity are not known.

#### Ethnicity

Applicants will identify yes or no if they consider themselves of Hispanic ethnicity.

- **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. (*For example: Puerto Rican, Cuban, Mexican, etc.*)



## Appendix B: Self-Certification of Annual Income (Workforce)

### 3. Residential Address Information

Address Line 1: (Optional)	City: (Required)
Address Line 2: (Optional)	County: (Required)

### 4. Please indicate your current family size and income in the following table.

"Family" means one or more persons living in your household who are related by birth, marriage, or adoption. Number of persons in your family shall reflect all family members, including those temporarily away from the home (e.g., college students, persons on extended vacation, etc.).

Please Circle # of Persons in your Family	FAMILY ANNUAL INCOME CATEGORY			
	Ventura County			
	Please check your family income in the same row as the number of persons in your family.			
Extremely Low-Income	Low-Income	Moderate Income	Above Moderate Income	
1	\$0 - \$31,450	\$31,451 - \$52,400	\$52,401 - \$83,850	Greater than \$83,850
2	\$0 - \$35,950	\$35,951 - \$59,900	\$59,901 - \$95,800	Greater than \$95,800
3	\$0 - \$40,450	\$40,451 - \$67,400	\$67,401 - \$107,800	Greater than \$107,800
4	\$0 - \$44,900	\$44,901 - \$74,850	\$74,851 - \$119,750	Greater than \$119,750
5	\$0 - \$48,500	\$48,501 - \$80,850	\$80,851 - \$129,350	Greater than \$129,350
6	\$0 - \$52,100	\$52,101 - \$86,850	\$86,851 - \$138,950	Greater than \$138,950
7	\$0 - \$55,700	\$55,701 - \$92,850	\$92,851 - \$148,500	Greater than \$148,500
8 or more	\$0 - \$59,300	\$59,301 - \$98,850	\$98,851 - \$158,100	Greater than \$158,100

I certify that the information provided above is correct to the best of my knowledge.

Printed Name

Signature

/ /  
Date

**WARNING:** The information provided on this form is subject to verification by the Subrecipient, HCD or HUD at any time. Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government.



### 1. Family Size

Identify the row which appropriately determines the number of related persons in the household. This number includes all family members, including those temporarily away from the home (e.g., college students, persons on extended vacation, etc.)

### Family Income

Identify the income that appropriately indicates the total annualized income for the family. Income should be determined by computing the total income of all adult family members for the last three (3) months and then multiplying that number by four (4), including persons temporarily away from the family/house.

Note: Income is not limited to salaries, wages, and tips. All other forms of income as specified by the Internal Revenue Service Form 1040 should be included (e.g., payments received from social security, pensions, annuities, dividends, taxable interest income, tax exempt interest income, IRA distributions, etc.)

### 2. Residential Address Information

Applicant will enter their residential address and county in which they reside to ensure the correct annual income limits were used to make an income eligibility determination.

### 3. Certification

#### Printed Name and Signature

Self-certification form must be signed by the Applicant/Workforce Trainee.

#### Date

Enter the date the form was completed.