GLOBAL FATHERHOOD FOUNDATION

: Statement/Release Information

REF :International Health Care Workers Program

Applicant Information		
Full Legal Name:		**Date:**
Preferred Name:	**Birth Date**(xx/xx/xxxx)	**Social Security Number**
Street Address:		
City: ☐ ☐ ☐	**State:**	**Zip:**
Phone: ☐ ☐ ☐ ☐ Cell: ☐ ☐ Home:	**Email:** ☐ ☐	

Are you a citizen of the United States?

YES ☐ NO - Eligible Non-Citizen ☐ No - Non-Citizen, not authorized to work ☐

Are you a Veteran? YES ☐ NO ☐ Eligible Spouse? YES ☐ NO ☐

Are you homeless? ☐

YES NO If yes, what is your mailing address? _____

How did you hear about us?

DEED Website	Virtual Hiring Event	Counselor_____
Flyer	Unemployment Session	Agency or School Referral
☐ CareerForce	Organization Website	Other: _____

What is your primary interest at this time?

☐ Getting a full-time job with little or no training

Are you interested in our career pathway training programs?

If so, which one: _____

Other: _____

Do you have an employment/job counselor?

YES NO If yes, who? _____

CERTIFICATION STATEMENT/RELEASE OF INFORMATION

I understand that I am being asked to provide private information on the Organization Name to enable the Organization Name to assist me. I understand this information may be shared with others and allowed by law but only after I have received and signed the full Department of Employment and Economic Development Notice How We Use Your Personal Information. I acknowledge and agree that all data I enter will be available to the Organization Name. I further acknowledge and understand that all data entered is subject to the Minnesota Government Data Practices Act.

I acknowledge that by electing to receive my information via email in a non-secure manner that the information will not be encrypted, and that it could be intercepted & viewed by a third party. Organization Name is not responsible for unauthorized access to your information in transmission to the email address you designated above.

Signature	
Client Signature:	Date:

Application Details

REF :International Health Care Workers Program

APPLICANT INFORMATION

Full Legal Name:	Gender/Pronoun:	Date:

EDUCATION INFORMATION

Highest grade completed / School Status: High School Diploma GED

If no High School Diploma, what is the highest grade level you have completed? (0-12)_____

College or Other Degree:

License or Certificate Attained _____

Currently Attending, Program_____Start Date: _____

Attended Some Years of College, No Degree If Yes, how many years of college? _____

Associate's Degree, Program_____Completion Date:_____

Bachelor's Degree, Program_____Completion Date:_____

Master's Degree, Program_____Completion Date:_____

Adult Basic Education English Language Learner (ELL) Classes

Have you recently completed any math or reading tests through high school, college (Accuplacer), Adult Basic Education, or other? YES NO If yes, when was it completed? _____

HOUSEHOLD INFORMATION

- **Family Member Name**: list all related family members who have lived with you in the past 6 months including parents, siblings, children and stepchildren. Please use additional paper if you have more than 5 family members.
- **Age**: list the ages of all family members
- **Relationship**: write your relationship to the listed family members (ex. spouse, child, etc.)
- **Check if Included in Tax Household**: check any family members who file taxes together with you.
- **Source of Income**: list each family member's source of income if they are included in your tax household. (ex. employment, Unemployment benefits, child support, Social Security, disability, etc.). If you or the family member listed do not have any income, write "none."
- **Total Amount of Income in the Past 6 Months:** list total of all sources of income for each family member listed.

	Family Member Name	Age	Relationship to You	Check if Included in Tax Household	Source of Income	Total Amount of Income in past 6 Months
1.	SELF		SELF	X		
2.						
3.						
4.						
5.						
		Actual Family Size		Eligible Family Size	Total Past Six Months:	

FOR OFFICE USE ONLY:			Total Annualized:	

EMPLOYMENT HISTORY

- List all paid employment held in the last 3 years, beginning with the most recent or current job. Attach additional job information on a separate sheet, if necessary.
- **Complete all sections. Dates must include month/day/year.**
- Check box if you have **No Paid Work History for the last 3 years.** ☐

Dates Employed	Employer Information	
From: Mo._____/Day_____/Yr To: Mo._____/Day_____/Yr Last Hourly Wage: __________ # of Hours Worked per Week:	Name	
	Address	
	City/State/Zip	
	Job Title	
Office Use Only: Amount Earned $	Job Duties	

Reason for leaving: ☐ Layoff ☐ Fired ☐ Strike ☐ Still Working
☐ Quit ☐ Medical ☐ Contract Ended ☐ Plant closing
☐ Department/shift eliminated ☐ Temp. Assignment Ended
☐ Accepted Buy-out Package ☐ Eligible for Trade Adjustment Act (TAA)
Did your job end due to COVID-19? ☐ YES ☐ NO

Expect to return to this employer?
☐ YES ☐ NO
If yes, when? __________
Do you belong to a union?
☐ YES ☐ NO

Dates Employed	Employer Information	
From: Mo._____/Day_____/Yr To: Mo._____/Day_____/Yr Last Hourly Wage: __________ # of Hours Worked per Week: ____________________	Name	
	Address	
	City/State/Zip	
	Job Title	
Office Use Only: Amount Earned $	Job Duties	

Reason for leaving: ☐ Layoff ☐ Fired ☐ Strike ☐ Still Working
☐ Quit ☐ Medical ☐ Contract Ended ☐ Plant closing
☐ Department/shift eliminated ☐ Temp. Assignment Ended
☐ Accepted Buy-out Package ☐ Eligible for Trade Adjustment Act (TAA)
Did your job end due to COVID-19? ☐ YES ☐ NO

Expect to return to this employer?
☐ YES ☐ NO
If yes, when? __________
Do you belong to a union?
☐ YES ☐ NO

Dates Employed	Employer Information	
From: Mo._____/Day_____/Yr To: Mo._____/Day_____/Yr Last Hourly Wage: __________ # of Hours Worked per Week: ____________________	Name	
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☐ Accepted Buy-out Package ☐ Eligible for Trade Adjustment Act (TAA)
Did your job end due to COVID-19? ☐ YES ☐ NO

Expect to return to this employer?
☐ YES ☐ NO
If yes, when? __________
Do you belong to a union?
☐ YES ☐ NO

Status of Unemployment Benefits (check one)

- ☐ Have not applied for Unemployment benefits
- ☐ Determined eligible for unemployment benefits. Amount per week $ _____
- ☐ Eligible for unemployment benefits, but not claiming. If not, why? _____
- ☐ Determined Ineligible for Unemployment. Reason _____
- ☐ Recently applied and pending Unemployment determination
- ☐ Exhausted Unemployment benefits ($0 account balance)

Were you dependent upon the income of another family member (not yourself) that you are no longer supported by? ☐ YES ☐ NO

Does anyone in the household receive income from Social Security (Retirement, Survivors, or Disability) or Supplemental Security Income? ☐ YES ☐ NO

If Yes, who receives it? _____

Do you have a disability? ☐ YES ☐ NO ☐ Choose not to disclose

If Yes, check all that apply: ☐ Physical Impairment ☐ Mental Impairment

☐ Both Physical/Mental Impairment ☐ Choose not to disclose

If Yes, do you feel your disability is a barrier to employment? ☐ YES ☐ NO

If Yes, do you require accommodations? ☐ YES ☐ NO

If Yes, what type of accommodations? _____

Do you feel you have limited English speaking ability? ☐ YES ☐ NO

If English is limited, do you require an interpreter? ☐ YES (specify language_____) ☐ NO

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to self-identify

Race: (Check all that apply) ☐ American Indian/Alaskan Native ☐ Hawaiian Native/ Pacific Islander

☐ Black/African American ☐ White ☐ Asian ☐ Choose not to self-identify

Your answer to this question is voluntary. Do you, a friend, or any member of your family have a history of opioid use? Please answer ☐ YES ☐ NO

CERTIFICATION STATEMENT/RELEASE OF INFORMATION

I certify that the information is true to the best of my knowledge. I am aware that the information I provide is subject to review and certification and I may have to produce documents to support this application. I am also aware that I am subject to 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 will be used to determine eligibility.

Signature

Applicant Signature: Date: