

Trumbull County Department of Job and Family Services

PREVENTION, RETENTION, AND CONTINGENCY PROGRAM (PRC) APPLICATION

Name of Applicant	Present Address	For Agency Use Only	
Social Security Number		Case Number	
Telephone Number Where You Can Be Reached		Date Sent	Date Returned
		County Trumbull	Unique ID

(1) **Have you or any household member received any type of assistance from the Job & Family Service Dept.** Yes No

If yes, give the county ODJFS, the type of assistance and the date received _____

(2) **Explain what you need, why and estimate the amount your are requesting.** _____

(3) **Give the name of other agencies you have contacted for help.**

(4) **Have any other agencies helped you with this need?** Yes No **If yes, name the agency and tell how you were helped. If no, tell why you were not helped.** _____

(5) **Complete the chart below for anyone in your home, including yourself. You are required to verify all income (earned and unearned) for all members of your household. If you are applying as a non-custodial parent responsible for the support of minor children, list those children below.**

Name	Relationship to Applicant	Age	Source of Income	Monthly Amount of Income
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
6.				\$

If you are eligible, the agency may limit assistance under this program to the documented amount of need within county guidelines.

Signature of Applicant	Date
-------------------------------	------

PREVENTION, RETENTION, AND CONTINGENCY PROGRAM (PRC)

Date Application received (mm/dd/yy) _____ 30 day budget period: From (mm/dd/yy) _____ To (_____ mm/dd/yy)

Request: List the items and /or services requested and the amount needed for each.

Item or Service	Amount Needed	Item or Service	Amount Needed
1.		3.	\$
2.		4.	\$

Reason for Need _____

Income (earned and unearned)

Source	Amount Available in Budget Period	Verification
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	

Total _____ (Compare to 200% of Federal Poverty Guidelines)

PRC Approved (complete chart) Date: _____ Check/Warrant Amount _____

Item/Service Provided	Date of Approval	Amount Paid	Vendor's Name and Address
		\$	
		\$	
		\$	

PRC Denied Date of denial (mm/dd/yy) _____ Date Notice of Denial of Application Sent (mm/dd/yy) _____

Reason for Denial: _____

Agency Representative Signature	Date	Signature of Supervisor	Date
---------------------------------	------	-------------------------	------

NOTICE OF APPROVAL OF YOUR APPLICATION FOR ASSISTANCE

Name	Assistance Group Name	
Street Address	Assistance Group Number	Program
City State and Zip Code	County	Mailing Date

Your application for _____ dated _____, has been approved, effective _____

Additional information: _____

The reason for this action is: _____

The rules that require this action are: _____

If you do not understand this notice, or want to talk to someone about it, you may call:

Caseworker	District/ID <p style="text-align: center; font-size: 1.2em;">78</p>	Phone Number <p style="text-align: center;">(330) 675-</p>
------------	--	---

Your Right to a State Hearing

This notice is to tell you about action we are taking on your case. If you do not understand this action, you may contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

If you do not agree with this action, you have a right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend or be represented at the hearing to present our reasons. A hearing officer from the Ohio Department of Job & Family Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

If you want a state hearing, check the appropriate boxes below, sign and date this form, and send it to the Ohio Department of Job & Family Services, State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

I want a county conference and a state hearing on this action.

I want a state hearing only.

I want a hearing.

Signature	Date	Phone Number
-----------	------	--------------

Now that you have been authorized for Prevention, Retention, and Contingency (PRC) services, you may be eligible for food stamp benefits. Please contact your county department of job and family services (CDJFS) if you wish to apply for food stamps. Keep this letter to verify that you have been authorized for PRC services. It will make a difference in the way your food stamp eligibility is determined. In addition, the CDJFS may need to request additional verification to determine eligibility for the Food Stamp program.

NOTICE OF DENIAL OF YOUR APPLICATION FOR ASSISTANCE

Name	Case Name	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

This notice is to tell you that your application for _____
dated _____, has been denied because:

The regulations supporting this denial are:

If you do not understand this proposed action or you want to talk to your caseworker about it, you may call:

Caseworker	District/ID	Telephone Number
------------	-------------	------------------

Your Right to a State Hearing

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After discussing the reasons for the action with your caseworker, it is possible that we will change our decision or that you will agree with the action.

If you do not agree with this action, you have a right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend or be represented at the hearing to present our reasons. A hearing officer from the Ohio Department of Job and Family Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date of this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services, but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-598-5888, for the local number.

If you want a hearing, sign your name, and send this form to the Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

9 I want a county conference and a state hearing on this action.

9 I want a state hearing only.

I want a hearing.

Signature	Date	Telephone Number
-----------	------	------------------

**NOTICE TO
COMMUNITY AGENCIES
ON
WHAT IS AVAILABLE THROUGH THE PREVENTION,
RETENTION, CONTINGENCY PROGRAM
AT
TRUMBULL COUNTY JOB AND FAMILY SERVICES
Effective March 1, 2005**

HELP WITH

EMPLOYMENT RELATED EXPENSES - tools, safety equipment, uniforms and work clothes

TRANSPORTATION - for employment, adult education or training activity - bus tickets, taxi fare, gas cards

SHELTER EXPENSES - court ordered evictions or foreclosure

HOMELESS SHELTER – Shelter Expense as defined

UTILITY DISCONNECT NOTICE - necessary for water, heating or cooking

AUTO REPAIR – Mechanical repair/Safety

EMPLOYMENT TRAINING SERVICES – Workforce Investment Act (WIA) “Priority of Service for Adults” for intensive and training Services as defined.

These services are available to eligible individuals with at least one minor dependent child or pregnant woman in their household who are at or below 200% FPL.

Restrictions do apply to some services. Individuals may apply by scheduling an appointment with their caseworker or if not currently a participant they may apply for PRC by coming into the agency to make application.

200% Federal Poverty Guideline
Assistance Group Size

Effective 2/18/05
200% Monthly (FPL)

1	\$1,596
2	\$2,140
3	\$2,682
4	\$3,226
5	\$3,770
6	\$4,312
7	\$4,856
8	\$5,400

NOTICE
to
PARTICIPANTS
of
OHIO WORKS FIRST
WHAT IS AVAILABLE THROUGH THE PREVENTION,
RETENTION, CONTINGENCY PROGRAM (PRC)
at
Trumbull County Job and Family Services
Effective March 1, 2005

HELP WITH

EMPLOYMENT RELATED EXPENSES - tools, safety equipment, uniforms and work clothes

TRANSPORTATION - for employment, adult education or training activity - bus tickets, taxi fare, gas cards

SHELTER EXPENSES - court ordered evictions or foreclosure

HOMELESS SHELTER – Shelter Expense as defined

UTILITY DISCONNECT NOTICE – **Water**, fuel necessary for heating or cooking.

AUTO REPAIR – Mechanical repair/Safety

EMPLOYMENT TRAINING SERVICES - Workforce Investment Act (WIA) “Priority of Service for Adults” for intensive and training services as defined.

These services are available to eligible individuals with at least one minor dependent child or pregnant woman in their household who are at or below 200% FPL.

Restrictions do apply to some services. Individuals may apply by scheduling an appointment with their caseworker or if not currently a participant they may apply for PRC by coming into the agency to make application.

200% Federal Poverty Guideline

Assistance Group Size

1	\$1,596
2	\$2,140
3	\$2,682
4	\$3,226
5	\$3,770
6	\$4,312

Effective 2/18/05

200% monthly FPL

7

\$4,856

8

\$5,400

WORKFORCE INVESTMENT ELIGIBILITY

Intake Date:

WIA Code:

First Name:

M. I.

Last Name:

Social Security Number:

Birth Date:

M

F

Street Address: _____

City: _____ State: _____ Zip: _____

County
Of Residence _____

County
of Service: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Message Phone No.: _____ Email Address: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: Asian Black/African American American Indian/Alaska Native

Native Hawaiian/other Pacific Islander White Other

Currently Employed? Yes No

Emergency Contact Name: _____ Phone: _____

UI Status at Intake:

- Exhaustee for Unemployment Insurance Not currently claimant and not an exhaustee
 Eligible claimant referred by WPRS Eligible Claimant not referred by WPRS

Education Level:

- No school grade completed Completed grade 1 Completed grade 2 Completed grade 3
 Completed grade 4 Completed grade 5 Completed grade 6 Completed grade 7
 Completed grade 8 Completed grade 9 Completed grade 10 Completed grade 11
 Completed grade 12, No diploma Attained Certificate of Equivalency for GED
 High School Graduate 1 yr. College 2 yrs. College 3 yrs. College
 4 yrs. College 5 yrs. College 6 yrs. College 7 yrs. College
 Associates Degree Bachelors Degree Masters Degree Doctoral Degree

Education Status:

- Student, H.S. or less Student, attending post H.S.
 Not attending school, H.S. dropout Not attending school, H.S. graduate

Seasonal Farm Worker? Yes No

Military Service? Yes No

Vietnam Veteran? N/I Yes No
Recently Separated?
Veteran Spouse?

Active Duty

Start Date	End Date

Disability % _____ Veteran Status _____

Campaign Served: _____

Valid Driver's License? Yes No State: _____

Class:

- Non-commercial
- CDL C-Under 26,001 lbs. If designed to transport 16+ occupants and/or transport placarded Hazm...
- CDL B-Over 26,000 lbs. combined vehicle with under 10,000 lbs. towed unit.
- CDL A-Over 26,000 lbs. combined vehicle with over 10,000 lbs. towed unit.

Registration Data:

Pell Grant Recipient? Yes No Family Size: _____
Public Assistance Recipient? Family 6 Month Income: _____
Dislocated Worker? Individual 6 Month Income: _____
Youth 5% window? Citizenship: US Citizen
Registered for Selective Services? Registered Alien
Selective Service Number _____ Refugee
 Other Legal Alien
 Other

Documented Reason for Eligibility:

- Cash Public Assistance Recipient
- Homeless
- System Calculated Low Income
- Food Stamps-Receives or Eligible to...
- Foster Child
- Disability Individual Income
- 5% Window Override
- None

Youth Barrier Documentation:

- Basic literacy skills deficient
- School Dropout
- Homeless
- Runaway
- Pregnant or Parenting Youth
- Offender
- Requires Additional Assistance
- Foster Child
- Disability (5% Only)
- Face Serious Barriers (5% Only)
- Basic Skills Deficient (5% Only)
- Behind Grade Level (5% Only)
- None

Barriers Data:

	Yes	No		Yes	No
Disabled?	<input type="checkbox"/>	<input type="checkbox"/>	Homeless?	<input type="checkbox"/>	<input type="checkbox"/>
Single Parent?	<input type="checkbox"/>	<input type="checkbox"/>	Offender?	<input type="checkbox"/>	<input type="checkbox"/>
Runaway?	<input type="checkbox"/>	<input type="checkbox"/>	Foster Child?	<input type="checkbox"/>	<input type="checkbox"/>
Limited English Proficiency?	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant/Parenting Youth?	<input type="checkbox"/>	<input type="checkbox"/>
Behind Grade Level?	<input type="checkbox"/>	<input type="checkbox"/>	Youth Requires Additional Assistance?	<input type="checkbox"/>	<input type="checkbox"/>
Basic Skills Deficient?	<input type="checkbox"/>	<input type="checkbox"/>	School Dropout?	<input type="checkbox"/>	<input type="checkbox"/>
Basic Literacy Skills Deficient?	<input type="checkbox"/>	<input type="checkbox"/>	Face Serious Barriers?	<input type="checkbox"/>	<input type="checkbox"/>

Date of Eligibility Determination: _____

Tested Reading Skills Grade Level: _____

Tested Math Skills Grade Level: _____

Dislocated Worker

is applicant a dislocated worker? Yes No

Which best describes reason for dislocation:

Was terminated, laid off, or receive a notice of termination or layoff from employment, eligible for or exhausted entitlement to U.I., not eligible for U.I., is unlikely to return to previous industry or occupation.

Was terminated or received a notice of termination due to permanent closure of plant, facility, or enterprise.

Was terminated or received a notice of termination due to substantial, layoff at a plant, facility, or enterprise.

Was long-term unemployed with limited opportunities for employment or reemployment in the same or similar occupation in the area in which the individual resides - Includes older workers with substantial barriers to employment by reason of age.

Was self-employed (including farmers, fishermen, ranchers) and is unemployed as a result of natural disasters, or general economic conditions.

If the applicant received a notice of termination or layoff, date received: _____

Dislocation wage: _____

Occupation at dislocation: _____

Record tenure in years with employer of dislocation: _____

Enter date of qualifying dislocation: _____

Enter WARN identifier number: _____

FAMILY INCOME. STATEMENT

1. Family Member(s) Names	2 Relationship	3. Age	4. Income Source/Agency	5. Excludable	6. Includable
	Self				

a) Did all of the people listed above live with you the entire month? y N

b) Were you supported by your family during the last 6 months? y N

c) If you are an eligible U.I. claimant, what is your weekly amount? \$ _____

Total includable 6 month income \$ _____
 Total Family Members supported by income _____
 If you had no income, how where you supported? _____

APPLICANT SIX MONTH WORK HISTORY

Employer Name and Address	Job Title	Start Date	End Date	Reason For Termination	Hourly Wage	Hours Per Week

Certification: To be signed after the applicant review information. I certify to the best of my knowledge the information above is accurate and true. I understand that all information is subject to verification. Falsification shall be grounds for termination and may subject the applicant to prosecution under the law.

Signature of Applicant Date

Signature of Parent/Guardian Date

Signature of Interviewer Date

Reviewer's Initials Date

Recertification: To be assigned after the applicant reviews information. I certify to the best of my knowledge the information above is accurate and true. I understand that all information is subject to verification. Falsification shall be grounds for termination and may subject the applicant to prosecution under the law.

Signature of Applicant

Date

Signature Parent/Guardian

Date

Signature of Interviewer

Date

Reviewer's Initials

Date

REFERRAL FOR TRANSPORTATION SCHEDULE

START DATE: _____

CLIENT NAME: _____ PHONE: _____

ADDRESS: _____ CITY/ZIP: _____

CASE NUMBER: _____ S. S. NUMBER: _____

WORK/TRAINING SITE: _____

ADDRESS: _____ PHONE: _____

DO YOUR CHILDREN REQUIRE DAYCARE? _____ YES _____ NO

DAYCARE NAME: _____ PHONE: _____

DAYCARE ADDRESS: _____

CHECK MARK WHAT THE TRANSPORTATION IS FOR:

_____ WEP

_____ JOB CLUB

_____ EMPLOYMENT

_____ EDUCATION/TRAINING

SPECIAL INSTRUCTIONS—PHYSICALLY CHALLENGED/WHEEL CHAIR VAN NEEDED.

CASE MANAGER SIGNATURE: _____

Casemanager completes all