FOR SOCIAL SERVICES USE ONLY		
NAME (LAST/FIRST)		
DATE COMPLETED		

477 EMPLOYMENT & TRAINING APPLICATION

(k^{h}anamakwst ntsayka munk-skukum ntsayka tilixam)

TOGETHER WE STRENGTHEN OUR PEOPLE

GENERAL INFORMATION

First Name	*Last Name*	*Age*	*Birthdate*

Street Address	*City*	*State*	*Zip*

Mailing address if different	*City*	*State*	*Zip*

Phone Number	*Message Number*	*County*

Tribe	*Roll #*	*Prior Client?* ☐ Yes ☐ No If yes, what program(s): _____

Gender ☐ Female ☐ Male ☐ Non Binary	*Age* 18 – 24? ☐ Yes ☐ No	*Email Address*
Have you ever served in the military? ☐ Yes ☐ No	*If 18 – 24:* Have you enlisted in the Selective Service? ☐ Yes ☐ No	*How many in the household?* _____ *Any Children under 18?* ☐ Yes ☐ No
Marital Status: ☐ Married ☐ Legally Separated ☐ Single		*Social Security Number*

Services of interest:

☐ Interview Preparation ☐ Resume Building ☐ Job Search ☐ Skill Building & Training

☐ Application Assistance ☐ Social Security Advocacy ☐ Education Assistance ☐ College/Diploma

☐ Required Employment Supplies (I.E. Tools, Specialized clothing, Certifications) ☐ Career Exploration

☐ Tribal Assistance ☐ Job Retention (Assistance Keeping Job) ☐ Financial Planning

Education (Check all that apply)

☐ Current Student ☐ High School Diploma/GED ☐ Some College ☐ Degree ☐ Certifications ☐ Highest Grade Completed ____

Do you have a current valid driver's license? ☐ Yes ☐ No	*What is Your Primary Source of Transportation?* ☐ Own Vehicle ☐ Public Transportation ☐ Friends/Family ☐ Walk/Bike

Current Employment Status ☐ Employed ☐ Unemployed ☐ Recently Hired

We respect your personal information and will honor your confidentiality

Income ☐ Wages ☐ Unemployment ☐ Child Support ☐ TANF ☐ School Loans ☐ SSD/SSI ☐ Tribal Disability

☐ Estimated total Monthly Household Income _____

Housing ☐ Rent ☐ Own ☐ Homeless ☐ Other _____

Barriers/Challenges:

☐ Childcare ☐ Education ☐ Housing ☐ Transportation ☐ Mental Health ☐ Support System

☐ Medical ☐ Criminal History ☐ Substance Use ☐ Reading/Writing/Math ☐ Other _____

List any other programs you are currently working with:

Office/Department: _____ ***Office/Department:*** _____

Office/Department: _____ ***Office/Department:*** _____

OPTIONAL:

Additional information you think would be helpful for us to know:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

We respect your personal information and will honor your confidentiality

AUTHORIZATION FOR RELEASE OF INFORMATION

To Our Clients: **We can better serve you if we are able to work with other entities that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.**

Name: _____ Date of Birth: _____

Tribal ID#: _____ Social Security #_____

Children: _____

I authorize the Social Services Department of the Confederated Tribes of Grand Ronde to obtain any applicable information from other entities, including records regarding:

Tribal Member Benefits	Tribal Employment Rights	Pacific Power & Light
Employment/Unemployment	Vocational Rehabilitation	Northwest Natural Gas Co.
Educational & Behavior Reports	Landlord/Owner	SSD/SSI
Alcohol & Drug Treatment	Probation/Parole Officer	Other as listed:
Mental Health Services	CTGR Human Resourses	_____
Medical & Psychiatric Treatment	Portland General Electric	_____

The Social Services Department of the Confederated Tribes of Grand Ronde is ***not*** authorized to contact the following entities: ***Please list specific agencies, organizations and/or individuals you do not authorize CTGR Social Services to contact.***

1.	5.
2.	6.
3.	7.
4.	8.

I agree that any entity contacted by Social Services Department Personnel may share & exchange information and coordinate services for me and my family: ☐ Yes ☐ No

This permission is good for one year or until revoked in writing.

I can cancel this authorization at any time, but understand that cancellation will not affect any information released prior to cancellation. I understand that information about my case is confidential and protected by State and Federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

If I am a Grand Ronde Tribal employee, I understand that the General Manager, or official designee will review my case.

☐ Client ☐ Guardian

☐ Parent ☐ Legal Custody

_____ _____

Signature Date

_____ _____ _____

Social Service Personnel Name Social Services Personnel Signature Date

To those receiving information under this authorization: **State and Federal law protect this information disclosed to you. You are not authorized to release information to any entity or person listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.**

I understand the purpose of this release as explained to me by the above-signed Case Worker. (Client Initials):_____

RIGHTS AND RESPONSIBILITIES

One of the goals of the Social Services Department and the Confederated Tribes of Grand Ronde is for you to become self-sufficient. However, if you do not comply with the program requirements you are participating in, you could lose eligibility for assistance from this program, other Tribal programs, and State programs (if applicable).

Client Responsibilities:

General:

- You agree to have a urinalysis on initial visit for Social Services programs, and random UA tests through the length of time you are receiving services.
- You agree to fill out all necessary paperwork completely and honestly, and provide monthly documentation required by the program.
- You are responsible for turning in all required documentation before receiving assistance. When estimates must be used, you are responsible for supplying receipts for all services provided.
- You are responsible for calling your Case Worker to schedule appointments, reschedule appointments, or to indicate that you will be late. Tardiness of 15 minutes of more will result in rescheduling the appointment to avoid overlapping with another client's scheduled appointment.
- You agree to contact your Case Worker to provide an update of your situation at least once each month while in the program. If you do not, your case may be closed.
- You agree to communicate openly with your Case Worker and report any changes that might affect your status. This include employment status, illness, and pregnancy, dropping out of school, or reducing work or school hours.

Employment & Training Program Participants:

- You agree to attend and complete activities listed in your Employability Development Plan (EDP).
- You agree to follow through on referrals to other Tribal programs for additional services as identified in your EDP.
- You are responsible for attending scheduled interviews and contacting your Case Worker after the interview for an update.
- You must follow through on any pre-employment procedures such as drug screenings or physicals.
- If you are employed, you are responsible for maintaining you job if it will help your career in the future.

Client Rights:

- You have the right to use the appeal process if a dispute cannot be resolved through conciliation.
- You have the right to be treated with dignity and respect.
- You have the right to participate in the development of your Employability Development plan (EDP) (if applicable).
- You have the right to a copy of your EDP (if applicable).

What happens if you do not comply with the program requirements?

Failure to comply with the program requirements could lead to termination from the program. However, the first step in the termination process is conciliation. If through the conciliation process the issue is not resolved, you may be terminated from the program. A Termination Notice will be sent to you by certified mail. If you choose not to respond to the Termination Notice, a discharge summary will be completed and placed in your file. If you eventually comply with the program requirements, your case may be reopened. Situations that may lead to termination are:

1. Exhibiting dishonesty, misstatements, misrepresentation, or omission of facts.
2. Failure to comply with program requirements.
3. Moving outside the six-county service area.
4. Failure to keep two (2) scheduled appointments.

Employment & Training

5. Failure to contact your Case Worker once a month and turn in Activity Forms by the 20th of each month.
6. Failure to comply with Employability Development Plan (EDP).
7. Failure to accept a reasonable employment offer.
8. Exhibiting a pattern of employment termination for cause or misconduct (if applicable).

Dispute and Conciliation Process

The following describes the conciliation process including the length of conciliation:

Conciliation is a process for resolving misunderstandings, dissatisfaction, or disagreements related to an individual's participation in the program (for example, a dispute about the EDP or termination for lack of contact).

1. Either you or your Case Worker may request conciliation and it may be done by telephone if both parties agree.

2. Conciliation will continue for a period not-to-exceed 30 days, but may be terminated earlier if the dispute is resolved or cannot be resolved. During this time, a determination will be made as to whether you are complying with or without good faith.

3. If your Case Worker makes reasonable efforts to schedule conciliation and you fail to appear for the meeting, the conciliation process may be ended and your case closed.

4. If the conciliation ends without resolution, a letter of notification will be sent along with the information on the right to appeal and the appeal process.

5. Appeals cannot and will not be instituted until the completion of the conciliation process. If existing disputes are resolved through the conciliation process, appeals will not be instituted.

Client Signature: _____ Date: _____

Case Worker Signature: _____ Date: _____

For People Who Cannot Write

I understand this form and am completing it voluntarily. I cannot write. I am placing my mark by my name to sign this form.		
Client's Full Name:	Client's Mark:	Date:
Witness #1:	Address:	
Witness #2:	Address:	

For People Who Cannot Read

I have read the form to the Client. He/She understands it and signed it voluntarily.		
SS Personnel Name:	Signature:	Date:

Please read the following statement to the client:
Supplying your Social Security number is voluntary and in general, refusing to supply your Social Security number cannot be used to deny services. However, it is necessary for identifying records for Employment and Vocational Rehabilitation information. In either case, if supplied, the Social Security number may be used to enforce agency regulations.

Waiver/Release

When applying for services through the Confederated Tribes of Grand Ronde, applicants are asked to provide information about themselves and their families, including Social Security numbers for all family members. Any information provided for the purpose of applying for services is kept strictly confidential in accordance with State and Federal law. Except as explained below, information will not be shared with other agencies or individuals without your written consent.

Supplying the requested Social Security numbers is voluntary on your part and, in general, your refusal to supply this information cannot be a basis for denying services. However, Social Security numbers are necessary for identifying records related to employment and vocational rehabilitation information. In either case, if supplied, the Social Security number may be used to enforce agency regulations.

Communicating with other agencies or individuals is helpful to the Grand Ronde Social Services Department in verifying information on your application, in determining eligibility for assistance, and when advocating for additional services. It is our policy to require proof of qualifying information in each client's application. You will be requested to sign a written *Authorization for Release of Information* permitting Social Services to communicate with specific agencies or individuals. Signing such an authorization is voluntary on your part but you should be aware that your refusal to do so might adversely affect your eligibility determination or coordination of services. If you decide not to sign, we will attempt to refer you to alternative services or agencies, which may be able to help you without an exchange of information.

The Grand Ronde Social Services Department respects the confidentiality of its clients. However, there are certain limits and exceptions to this confidentiality. Information will not be released to outside agencies or private individuals without your written consent except under the following circumstances:

- Where there is reason to suspect the occurrence of child abuse, spousal abuse, or elderly abuse.
- When there is clear, imminent danger to yourself and/or others.
- By direct order from court having jurisdiction in accordance with Federal regulations.
- Where there is reason to suspect criminal conduct.

Grand Ronde staff are not licensed clinical social workers, professional counselors, doctors or lawyers unless their documented credentials indicate otherwise. Grand Ronde staff are not qualified to provide mental health diagnosis, counseling, physical diagnosis, or legal advice unless they have documented credentials qualifying them to do so. If you request these services, you may be referred to qualified staff members or to other agencies with appropriate expertise.

Federal Law Governing Fraud: Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or devises a material fact, or makes any false, fictitious, or fraudulent statements, or representatives or makes or uses any false writings or documents, knowing the same to contain any false, fictitious, or fraudulent statements or entry, shall be fined not more than $10,000, or imprisoned more than five years, or both.

In the event fraud has been committed, applicant(s) may be banned from receiving assistance through the Grand Ronde Social Services Department for a period of up to one year.

I (we) have read, or heard read, or have had interpreted to me (us) the preceding provisions of law and understand them. I (we) agree to supply all necessary information about my (our) situation changes. I (we) also authorize the **Confederated Tribes of Grand Ronde Community of Oregon** to obtain information necessary to establish my (our) eligibility for assistance. By my (our) signature, I (we) verify that all the above information necessary to establish my (our) eligibility for assistance. By my (our) signature, I (we) verify that all the above information on this application and any oral information given is true and correct to the best of my (our) knowledge.

Signature of Applicant: _____ Date: _____
Signature of Spouse/Partner of Applicant

-OR- Parent of Minor Applicant: _____ Date: _____

Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

Legal last name:	**First name:**	MI:	Date of birth:
Other names:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification type: Pick one			

When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.

Release FROM:

Purpose of the disclosure, sharing and use:	
Entity name: Pick one	
Date of records: Pick one	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Fax number:	Mutual exchange: ○ Yes ○ No
Expiration date or event*:	

Do you request special health information to be released? ◉ Yes ○ No

Specially protected information: (*There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that* ***no information*** *will be disclosed* ***unless*** *I or my representative* ***initial next to the information types below.***)

HIV or AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol or drug diagnoses, treatment, referral: _____

Is there any specific information **not** to release? ○ Yes ○ No

Release TO:

Purpose of the disclosure, sharing and use:	
Entity name: Pick one	
Date of records: Pick one	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Fax number:	Mutual exchange: ○ Yes ○ No
Expiration date or event*:	
Is there any specific information **not** to release? ○ Yes ○ No	

Your acknowledgment

- I was given the chance to ask questions about this form and what it does.
- I understand what this form means and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from any listed:
  » Agency » Business » Organization » Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.*
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  » Drug and alcohol diagnosis » HIV and AIDS information » Mental health
  » Referral information » Treatment records » Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information may no longer be protected under federal or state law.
- I understand someone may need to contact me about this form to confirm my identity. They may also need to get more information.
- I understand that deciding not to sign this form may:
  » Prevent agencies from deciding if I am eligible for certain programs.
  » Prevent me from getting referrals. It may also make coordination of provider services more difficult.
  » Affect my ability to get health services if it is necessary to share information.
  » Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.
- **I am signing this authorization of my own free will.**

Signature:	
Printed name:	Date:

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could go to someone you don't want to have the information. If you are not sure how to send a secure email, consider using regular mail or fax.

For questions or help to complete this form, please contact the agency you work with.

- *Oregon Health Authority: 503-947-2340*
- *Oregon Department of Human Services: 503-945-5600*
- *Oregon Commission for the Blind: 971-673-1588*
- *Oregon Department of Employment: 800-237-3710*
- *Oregon Department of Education: 503-947-5600*
- *Oregon Housing and Community Services: 503-986-2000*
- *Oregon Department of Justice: 503-378-4400*
- *Oregon Department of Corrections: 503-945-9090*
- *Oregon Youth Authority: 503-373-7205*
- *Oregon State Police: 503-378-3720*

* *This authorization is valid for one year from the date I sign it, unless otherwise noted.*

Instructions by section

When you submit the form, you do not need to include the instruction pages.

Creating preset templates
To save time, you can preset the number and type of sections. You can also prefill your organization's information, then save template versions of this form for quick printing. Use the non-printing "Template" field in the top right corner of the form and name the template for your future reference.

Release TO and FROM sections	
Purpose of disclosure, sharing and use	• Give specific reasons why the information disclosure, sharing and use are needed. • If the person does not want to provide a reason in this field the requesting entity may include the statement "at the request of the person" as the purpose the person initiates the authorization.
Entity name (*drop-down list*)	• Choose an entity from the drop-down list. • If the entity is not listed, choose "Other (please type in here):" Then, type in the entity's name. An entity's name must be specific. For example, listing "medical" or "service provider" is not adequate. Please list the name of the medical or service provider. For a person or other type of organization, such as a school or employer, list the name of the person or other type of organization.
Specific information to be disclosed (*pops up after an entity is selected*)	• Choose a document type from the drop-down list. • If an information type is not listed, choose "Other (please type in here):" and type in a description. Some examples of specific information are: » Assessments » Case plans » Financial information » Medicaid billing summaries » Psychological reports » Results of urinalysis » Treatment plans • Do not indicate "entire record" unless it is necessary to accomplish the purpose (*see "Purpose of the disclosure, sharing and use", above*). • Use the buttons to add or delete additional requested information types, if you need to.
Date of records	• Indicate the specific date range for the requested records.
Expiration date or event	• This authorization is valid for one year from the date I sign. unless otherwise noted. For example, if "hospital discharge" or "end of litigation," is noted.
Mutual exchange	• A "Yes" allows the specific information listed on the form to go back and forth between the record holder and the people or programs listed on this authorization. Mutual exchange opens all requested records for discussion between the record requestor and specified record holders.
Did you request special health information to be released?	• Choosing "Yes" will display a section where special health information types can be stated. • A check mark in the space next to the type of health information is not enough. The person must initial the space next to the information if they agrees to release this information. • If you need this section visible in a printed copy, please make sure to choose "Yes" prior to printing.
Is there any specific information **not** to release?	• A "Yes" choice will display a text box where you can list specific information. • If any specific information should not be included when the records are released, please list them here. • If you need this section visible in a printed copy, make sure to choose "Yes" before to printing.

Re-disclosure	• Re-disclosure is the disclosure of information by the person on this form. • There may be restrictions on the re-disclosure of information released under this form. • Federal and state regulations prohibit re-disclosure of alcohol and drug, and HIV or AIDS information without specific authorization.
Adding requesting and releasing entities	• If there is a need for multiple requesting or releasing entities, use the ADD or REMOVE buttons to add or remove any additional "Releasing agency, business, organization or person" sections before you print the form.

Client acknowledgment section	
Signature of the person on this form or a person legally authorized to act for them.	• A person legally authorized to act for the person on this form should never be asked to sign a blank or incomplete authorization form.

Releasing entity: Document when records were shared.

- Entity must:
  - » Maintain a copy of the completed authorization form, either electronically or in paper file, and
  - » Following agency retention schedules.
- If completed authorization forms are stored electronically, a process shall be in place for cancellation. If a signed authorization is later (*cancelled*), that revocation must be noted electronically.
- Do not use labels on the authorization form.
- When completed correctly, the form is the only thing needed to process a disclosure.

Authorization for Release of Information

The CTGR Human Resources Temporary Services Pool has a strong partnership with TERO, 477, and VOC Rehab. We collaborate on clients to assist them in all employment related needs and barriers. This can include, but not limited to, nor guaranteed: training opportunities, financial assistance, on the job trainings and coaching. A release of information assures that we may collaborate among our programs to deliver you optimal service and opportunity.

I _____ certify that I give permission to The Confederated Tribes of Grand Ronde Human Resources Department to disclose my information to other CTGR entities such as, but not limited to the Tribal Employment Rights Office and Social Services in order to assist with my employment needs.

I, at any time, may revoke these privileges. I understand that cancellation will not affect any information shared prior to cancellation. I understand that information about my case is confidential and protected by State and Federal Law. I approve the release of this information. I understand what this agreement means, I am signing on my own and have not been pressured to do so.

_____	_____	_____	_____
Printed Name	**Signature**	**Tribal Roll #**	**Date**

_____	_____
Human Resources Representative	**Date**