FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #07-100-OPE

(This Policy Bulletin Replaces PB #02-158-OPE)

OBSOLETE WIA FORMS

Date: August 15, 2007	**Subtopic(s):** Forms
This procedure can now be accessed on the FIAweb. Related items: PB #07-29-EMP	The purpose of this policy bulletin is to inform staff that the following Workforce Investment Act (WIA) program forms have been made obsolete, as this program has been replaced by new employment initiatives. • Workforce Investment Act (WIA) Self-Sufficiency Guidelines for Adult Customers Applying for Intensive or Training Services (**WIA-4**) • Workforce Investment Act (WIA) Self-Sufficiency Guidelines for Customers Applying for Contracted Training Under Special Population Contracts (**WIA-4B**) • WIA Desk Reference Guide (**WIA-6**) • Workforce Investment Act (WIA) Special Population Certification Form (**WIA-6A**) • Authorization for Release of Confidential HIV-Related Information (**WIA-7**) • Workforce1 Career Center Customer Transfer Form (**WIA-8**) • Consent for Disclosure of Alcohol or Substance Abuse Treatment Program Information and Records (**WIA-9**) • Consent for Disclosure of Alcohol or Substance Abuse Treatment Program Information and Records (Spanish) (**WIA-9** [**S**]) • Workforce1 Career Center Referral to HRA Job Center (**WIA-10**) Center Directors must ensure that all versions of these forms, including multilingual equivalents, are removed from circulation and recycled. Samples of the obsolete forms are attached.

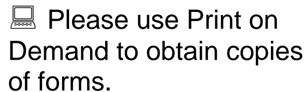
HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 2 at the prompt followed by 765 or
send an e-mail to *FIA Call Center*

Distribution: X

Effective Immediately

Related Items:

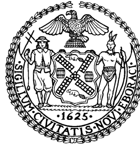
PB #07-29-EMP


Please use Print on Demand to obtain copies of forms.

Attachments:

WIA-4	Workforce Investment Act (WIA) Self-Sufficiency Guidelines for Adult Customers Applying for Intensive or Training Services (6/28/02) (Obsolete)
WIA-4B	Workforce Investment Act (WIA) Self-Sufficiency Guidelines for Customers Applying for Contracted Training Under Special Population Contracts (6/28/02) (Obsolete)
WIA-6	WIA Desk Reference Guide (Rev. 6/28/02) (Obsolete)
WIA-6A	Workforce Investment Act (WIA) Special Population Certification Form (6/28/02) (Obsolete)
WIA-7	Authorization for Release of Confidential HIV-Related Information (6/28/02) (Obsolete)
WIA-8	Workforce1 Career Center Customer Transfer Form (Rev. 7/12/02) (Obsolete)
WIA-9	Consent for Disclosure of Alcohol or Substance Abuse Treatment Program Information and Records (6/28/02) (Obsolete)
WIA-9(S)	Consent for Disclosure of Alcohol or Substance Abuse Treatment Program Information and Records (6/28/02) (Spanish) (Obsolete)
WIA-10	Workforce1 Career Center Referral to HRA Job Center (6/28/02) (Obsolete)

Form WIA-4
6/28/02



The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Workforce Investment Act (WIA)
Self-Sufficiency Guidelines for Adult Customers
Applying for Intensive or Training Services

The following income standards should be applied in establishing eligibility for individuals applying for intensive or training services under WIA contracts. An individual may be served who:

- Has an annual income at or below 80% of the median wage (see the chart below).

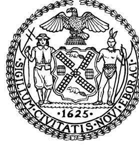
Note A: The income test should only be applied to the individual seeking services. The income of other household members is not taken into account for the purposes of this calculation.

Note B: To calculate the individual's annual income, take the total income over the last six months and multiply by two.

OBSOLETE

Self-Sufficiency Guidelines Gross Income Standards for Various Family Sizes (Annual Income)					
	Family Size				
	1	2	3	4	5
Public Assistance Case Closed	8,880	11,508	13,908	16,368	18,876
Removal of Food Stamp Benefits	13,548	16,260	18,048	21,720	25,380
Lower Living Standard Income Level	11,029	18,071	24,800	30,614	36,129
200% Poverty	17,334	22,966	26,846	33,908	39,156
80% Median	31,450	35,950	40,450	44,950	48,550

Form WIA-4B
6/28/02



The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Workforce Investment Act (WIA) Self-Sufficiency Guidelines for Customers Applying for Contracted Training Under Special Population Contracts

The following income standards should be applied in establishing eligibility for contracted training under the Special Population Contracts. An individual may be served who:

- Falls into a WIA Special Population participant category; and
- Has an annual income that falls at or below the WIA guidelines below; or
- Receives, or is a member of a family that receives federal, state or local public assistance grants, including SSI and food stamps;
- Is homeless;
- Is a foster child for whom government payments are made.

OBSOLETE

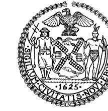
Note A: The income test must be calculated based on the income of the entire household, except that an individual with a disability whose own income meets the requirements of the program is eligible regardless of his/her total family income.

Note B: Excluded from the income test for this purpose are: unemployment compensation, child support payments, public assistance grants and social security old age and survivor benefits.

Note C: To calculate the annual income, take the total household income over the last six months and multiply by two.

Self-Sufficiency Guideline for Training and Credential Milestone Gross Income Standards for Various Family Sizes (Annual Income)						
	Family Size					
	1	**2**	**3**	**4**	**5**	**6**
Maximum Amount for Each Family Size	8,860	15,340	18,320	22,610	26,680	31,210
"2002 HHS Federal Poverty Guidelines"						

Form WIA-6
6/28/02



The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

WIA Desk Reference Guide

WIA Adult Registration & Eligibility Guidelines

Four Basic Eligibility Requirements for Enrollment into WIA:

1. Age (18 years or older)
2. Social Security Number
3. Citizenship (United States Citizen or Resident Alien)
4. Selective Service Registration (for males born after December 31, 1959)

Documents must be collected to verify age, social security number, citizenship, and selective service registration. Photocopies of the documents must be included in the customer's case record.

OBSOLETE

Age:

Any one of the following documents is sufficient: Birth Certificate, DD-214 Report of Transfer or Discharge Paper, Driver's License, Federal, State, or Local Governmental Identification Card, Hospital Record of Birth, Passport, Public Assistance/Social Service Records, School Records/Identification Card, Social Security Administration NUMI Printout, Certificate of Birth from Bureau of Vital Statistics, Marriage Certificate with Date of Birth, Baptismal Certificate, Draft Registration, Military Identification Card.

Social Security Number:

Any one of the following documents is sufficient: Social Security Card, DD-214 Report or Transfer or Discharge Paper, Driver's License, Employment Records, IRS Form Letter 1722, Letter from Social Services Agency, Pay Stub, Social Security Administration NUMI Printout, Social Security Benefits, Social Security Card, W-2 Form.

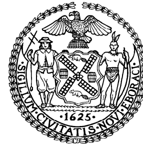
Citizenship:

Any one of the following documents is sufficient: Alien Registration Card indicating Right to Work (INS Forms I-151, I-551, I-94, I-688A, I-179, I-197), Birth Certificate, DD-214 Report of Transfer of Discharge, Food Stamp Records, Foreign Passport stamped Eligible to Work, Hospital Record of Birth, Naturalization Certificate, Public Assistance Records, Social Security NUMI Printout, U.S. Passport, Social Security Card.

Selective Service Registration:

Any one of the following documents is sufficient: Acknowledgement Letter, DD-214 Report of Transfer or Discharge Paper, SDA/(Service Delivery Area) State Registration Process, Selective Service Verification Form, Stamped Post Office Receipt or Registration, Selective Service Advisory Opinion Letter, Selective Registration Card, Selective Service Registration Record. If information is needed, contact the Selective Service at 708-688-6888.

Form WIA-6A
6/28/02



The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Workforce Investment Act (WIA)
Special Population Certification Form

OBSOLETE

Customer Information

Applicant Name ______________________ Case Number ______________________

Address ______________________ Telephone Number ______________________

______________________ E-mail ______________________

____

City State Zip

Eligibility Information

Social Security Number ______________________ Date of Birth ______________________

Citizenship ☐ U.S. Citizen ☐ Resident Alien

Selective Service Registration (Males 18 and older) ☐ Yes ☐ No

Special Population Category

- ☐ Disabled
- ☐ Developmental Disabilities
- ☐ HIV/AIDS
- ☐ Language/Cultural
- ☐ Domestic Violence Survivors
- ☐ Ex-Offenders
- ☐ Ex-Offenders (Older Youth)
- ☐ Substance Abuse
- ☐ Multiple Barriers
- ☐ Mature Workers
- ☐ Homeless
- ☐ Low Basic Skills
- ☐ Non-Custodial Fathers
- ☐ Veterans

Briefly explain the applicant's specific needs and verify that s/he meets the special population criteria.

____

____

____

____

List types of documentation accepted and attach copies to this form

____

____

____

____

For Internal Purposes Only

Contractor Name ______________________ Contractor Site Code ______________________

Contractor Staff Name ______________________ Signature ______________________

Contractor Telephone Number ______________________ Date ______________________

Authorization for Release of Confidential HIV-Related Information

Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has an HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV, including information pertaining to a person's contacts.

Under New York State Law, except for certain people, confidential HIV-related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV-related information without a release form.

If you sign this form, HIV-related information can be given to the people listed on the form, for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released:

OBSOLETE

Name and address of person signing this form (if other than above)

Relation to person whose HIV information will be released:

This release is authorized from ____________________ **to** ____________________ .

My questions about this form have been answered. I know that I do not have to allow release of HIV-related information, and I can change my mind at any time.

____

Signature/Date

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized or further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

* Human Immunodeficiency Virus that causes AIDS

Autorización para Divulgar Información Confidencial Relacionada con el VIH*

Información Confidencial Relacionada con el VIH es cualquier información indicando que una persona se ha sometido a un análisis relacionado con el VIH, o tiene una infección del VIH, una enfermedad relacionada con el VIH o SIDA, o cualquier información que pudiera indicar que una persona potencialmente ha sido expuesta al VIH, incluyendo información correspondiente a los contactos de la persona.

Bajo las Leyes del Estado de Nueva York, con excepción a ciertas personas, información confidencial relacionada con el VIH solamente puede ser proporcionada a personas que usted permita que la tenga al firmar una divulgación. Usted puede pedir por una lista de personas que pueden ser proporcionadas información confidential relacionada con el VIH sin un formulario de divulgación.

Si usted firma este formulario, información relacionada con el VIH puede ser proporcionada a las personas listadas en el formulario, por la(s) razón(es) listada(s) en el formulario. Usted no tiene que firmar el formulario, y puede cambiar de opinion en cualquier momento.

Si usted experimenta discriminación por causa de la divulgación de información relacionada con el VIH, puede comunicarse con la División de Derechos Humanos del Estado de Nueva York (New York State Division of Human Rights) al (800) 523-2437 o la Comisión de Derechos Humanos de la Ciudad de Nueva York (New York City Commission on Human Rights) al (212) 306-7500. Estas agencias son responsables por proteger sus derechos.

OBSOLETE

Nombre de persona de la cual la información relacionada con el VIH será divulgada:
Nombre y dirección de la persona firmando este formulario (si es diferente a la de arriba) **Relación a la persona cuya información del VIH será divulgada:**
Esta divulgación es autorizada de ______________________ **a** ______________________ **.**

Mis preguntas acerca de este formulario han sido contestadas. Yo se que no tengo que permitir la divulgación de información relacionada al VIH, y que puedo cambiar de opinión en cualquier momento.

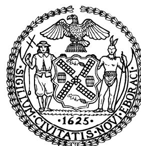
____

Firma/Fecha

Esta información ha sido divulgada a usted de expedientes confidenciales los cuales están protegidos por leyes estatales. Las leyes estatales le prohiben de hacer revelación adicional de esta información sin el consentimiento por escrito específico de la persona a quien le pertenece o como sea de otra manera permitido por la ley. Cualquier divulgación no autorizada o adicional en violación de leyes estatales puede resultar en una multa o sentencia de encarcelamiento o ambas. Una autorización general para la divulgación de información médica u otra información no es suficiente autorización para revelación adicional.

* Virus de Inmunodeficiencia Humana que causa el SIDA

Form WIA-8
Rev. 7/12/02



The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Workforce1 Career Center Customer Transfer Form

Customer Name: ______________________

Social Security Number: ______________________

Address: ______________________

____

____
City State Zip Code

Telephone Number: ______________________

E-mail Address: ______________________

Assigned Workforce1 Career Center: ______________________

Requested Workforce1 Career Center: ______________________

Address: ______________________

Reason for requesting transfer: ______________________

I am a Workforce1 Customer. I am requesting that my employment services records be transferred to the requested Workforce1 Career Center indicated above.

____
Signature Date

OBSOLETE

Formulario del Centro de Carreras Workforce1 para el Traslado de Clientes

Nombre del Cliente: ______________________

Dirección: ______________________

____

____
Ciudad Estado Código Postal

Centro de Carreras Workforce1 Asignado: ______________________

Centro de Carreras Workforce1 Solicitado: ______________________

Dirección: ______________________

Razón por la cual se solicita el traslado: ______________________

Soy Cliente de Workforce1. Solicito que mis expedientes de servicios de empleo sean trasladados al Centro de Carreras Workforce1 solicitado que aparece más arriba.

____
Firma Fecha

Internal Purposes Only *(To be completed by HRA Contractor - Please print clearly in black ink!)*

Requested Workforce1 Career Center Information

Contractor Staff Name: ______________________

E-mail address (for confirmation): ______________________

WISARD Site Code: ______________________

WISARD ID (MAPPER ID): ______________________

____
Contractor Staff Signature Date Telephone Number

Form WIA-9 (face)
6/28/02

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Consent for Disclosure of Alcohol or Substance Abuse Treatment Program Information and Records

Federal law and regulations protect confidentiality of alcohol and substance abuse treatment records. In general, the program to which you were referred or are now attending, or attended in the past may not disclose to anyone, any program information regarding your treatment, and may not disclose any information identifying you as an alcohol or substance abuser, unless you consent in writing to such disclosure.

Sign AFTER you read and understand the consent you are giving. You may ask questions about anything you do not understand.

I, ____ (participant's name), authorize and request

(i) ____ (treatment provider with provider code), (ii) the New York City Human Resources Administration, (iii) the Workforce Investment Act, (iv) the National Association on Drug Abuse Problems Substance Abuse Centralized Assessment Program (SACAP) and (v) the New York State Office of Temporary and Disability Assistance (OTDA), to communicate with and disclose to each other the following information:

1. My name, address and other personal identifying information.
2. Results of any formal alcohol or substance abuse assessment(s) performed by an alcohol or substance abuse counselor credentialed by the New York State Office of Alcoholism and Substance Abuse Services.
3. Prior alcohol/substance abuse treatment.
4. Referral(s) made to an appropriate treatment program(s).
5. Date(s) of admission(s) or referral(s) to any treatment program.
6. Diagnoses and prognosis made by treatment program(s).
7. Assessment results and history, including evaluation of psychosocial and vocational functioning.
8. Treatment plan, progress, and compliance.
9. Toxicology results.
10. Attendance/Removal roster.
11. Discharge plan, date of discharge and discharge status.
12. Employment, education and training related information.
13. Other: ________________________________

I authorize the release of the above information to the above organizations to share and communicate with each other for the purpose of screening and assessing my need for appropriate alcohol or substance abuse treatment; making a referral to an appropriate treatment program; monitoring my progress and attendance in a treatment program; monitoring my participation and compliance with treatment; verifying my eligibility for public assistance and assisting in my achievement of sobriety and economic self-sufficiency.

I understand that this release does not authorize the disclosure of confidential HIV-related information. I also understand that information released/shared pursuant to this consent will not be re-released to any organization or individuals except to those organizations or individuals that I have authorized to share information in this consent.

OBSOLETE

If I am required to apply for benefits furnished by the Social Security Administration, I understand that the information specified in this consent form may be shared with the Social Security Administration for the limited purpose of applying for benefits from the Social Security Administration.

I understand that I may revoke my consent at any time, except to the extent that the treatment program listed or the City or State agency or the National Association on Drug Abuse Problems Substance Abuse Centralized Assessment Program (SACAP), which is to make the disclosure, has already taken action in reliance on my consent. If not previously revoked, this consent will terminate **upon the termination of my participation in the WIA program.**

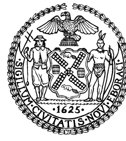
Signature of Participant | Date

Signature of parent, guardian or person authorized to sign (in lieu of participant, where required) | Date

NADAP Counselor/CASAC | Date

OBSOLETE

Form WIA-9 (S) (face)
6/28/02



The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Consentimiento para Revelar Información y Registros de Programas de Tratamiento para el Abuso de Alcohol o Substancias

La Ley y reglamentaciones Federal protegen la confidencialidad de registros de tratamiento de abuso de alcohol y substancias. En general, el programa al cual usted fue referido o al cual está asistiendo actualmente o asistió en el pasado, no puede divulgar a nadie, ninguna información relacionada a su caso, y no puede divulgar información que le identifique como una persona que abusa de alcohol o substancias, a menos que usted consienta por escrito a dicha divulgación.

Firme DESPUES de que usted lea y entienda el consentimiento que está otorgando.
Usted puede hacer preguntas sobre cualquier cosa que no entienda.

I, ______________________________ (nombre del participante), autorizo y solicito

(i) ______________________________ (proveedor de tratamiento con código), (ii) la Administración de Recursos Humanos de la Ciudad de Nueva York, (iii) Ley de inversión Laboral (Workforce Investment Act), (iv) Programa de Evaluación Centralizado de Abuso de Sustancias de la Asociación Nacional de Problemas de Abuso de Droga (National Association on Drug Abuse Problems Substance Abuse Centralized Assessment Program - SACAP) y (v) la Oficina de Asistencia Temporaria y de Incapacidad del Estado de Nueva York (New York State Office of Temporary and Disability Assistance - OTDA), para comunicarse con y revelar el uno al otro la siguiente información:

OBSOLETE

1. Mi nombre, dirección y otra información de identificación personal.
2. Resultados de cualquier evaluación(es) formal sobre abuso de alcohol o de substancias realizada por un consejero de abuso de alcohol o substancias acreditado por la Oficina de Servicios Alcoholismo y Abuso de Substancias del Estado de Nueva York.
3. Tratamientos de alcohol/abuso de substancias anteriores.
4. Referencia(s) hechas a un programa(s) de tratamiento apropiado.
5. Fecha(s) de admisión(es) o referencia(s) a cualquier programa de tratamiento.
6. Diagnostico y pronóstico hechos por el(los) programa(s) de tratamiento.
7. Resultados e historial de evaluación, incluyendo evaluación de funcionamiento sico-social y vocacional.
8. Plan de tratamiento, progreso, acatamiento.
9. Resultados de toxicología.
10. Lista de Asistencia/Remoción.
11. Plan de descargo, fecha de descargo y estado de descargo.
12. Información relacionada a empleo, educación y entrenamiento.
13. Otro: ______________________________

Yo autorizo la revelación de la información que aparece arriba a las organizaciones que aparecen arriba para compartir y comunicarse el uno al otro con el propósito de examinar y evaluar my necesidad para tratamiento apropiado de abuso de alcohol y substancias; a hacer una referencia a un programa de tratamiento apropiado; verificar mi progreso y asistencia en un programa de tratamiento; verificar mi participación y acatamiento al programa; verificar mi elegibilidad para asistencia pública y asistirme en mi logro de sobriedad y autosuficiencia económica.

Yo entiendo que esta comunicación no autoriza revelar información confidencial relacionada a VIH. Yo también entiendo que la información revelada/compartida consiguiente a este consentimiento, no será revelado de nuevo a ninguna organización o individuos excepto aquellas organizaciones o individuos a los cuales he autorizado a compartir información en este consentimiento.

Si se me requiere que solicite beneficios proveídos por la Administración del Seguro Social, yo entiendo que la información especificada en este formulario de consentimiento puede ser compartida con la Administración de Seguro Social para el propósito limitado de solicitar beneficios de la Administración de Seguro Social.

Yo entiendo que puedo revocar mi consentimiento en cualquier momento, excepto hasta el punto en el cual el programa de tratamiento listado o la agencia de la Ciudad o del Estado o Programa de Evaluación Centralizado de Abuso de Sustancias de la Asociación Nacional de Problemas de Abuso de Droga (SACAP), la cual es derevelar la información, ya ha tomado acción debido a mi consentimiento. Si no fue anteriormente revocado, este consentimiento será terminado **al terminarse mi participación en el programa de la WIA.**

Firma del Participante	Fecha
Firma del padre/madre, guardián o persona autorizada para firmar (en nombre del participante, donde sea requerido)	Fecha
Consejero de NADAP/CASAC	Fecha

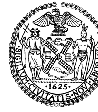
OBSOLETE

Form WIA-10
6/28/02

Case Number: ______________________

Name of Applicant: ______________________

SSN: ______________________



Workforce1 Career Center Referral to HRA Job Center

Dear Applicant:

You have expressed an interest in enrolling at this Career Center for assistance in job placement and/or training services provided under the Workforce Investment Act (WIA). Our records indicate that you have an active public assistance case. Therefore, we must refer you to your Job Center where an HRA Job Opportunity Specialist (JOS) will assign you to an appropriate employment services and placement program.

Your Job Center is: ______________________

Name of Job Center

Address

City State Zip Code

Telephone Number

Fax Number

Contractor Staff Name Date Telephone Number

Número del Caso: ______________________

Nombre del Solicitante: ______________________

NSS: ______________________

Referencia del Centro de Carreras Workforce1 al Centro de Trabajo de la HRA

Estimado Solicitante:

Usted ha manifestado interés en inscribirse en este Centro de Carreras para obtener asistencia de servicios de colocación y/o entrenamiento para empleo provistos bajo la Ley de Inversión Laboral (Workforce Investment Act - WIA). Nuestros expedientes indican que usted tiene un caso activo de Asistencia Pública. Por consiguiente, tenemos que referirle a su Centro de Trabajo en donde un Trabajador de Servicios de Oportunidad de Empleo (JOS) lo asignará a un servicio apropiado de empleo y a un programa de colocación.

Su Centro de Trabajo: ______________________

Nombre

Dirección

Ciudad Estado Código Postal

Número de Teléfono

Número de Fax

Nombre del Personal Contratista Fecha Número de Teléfono