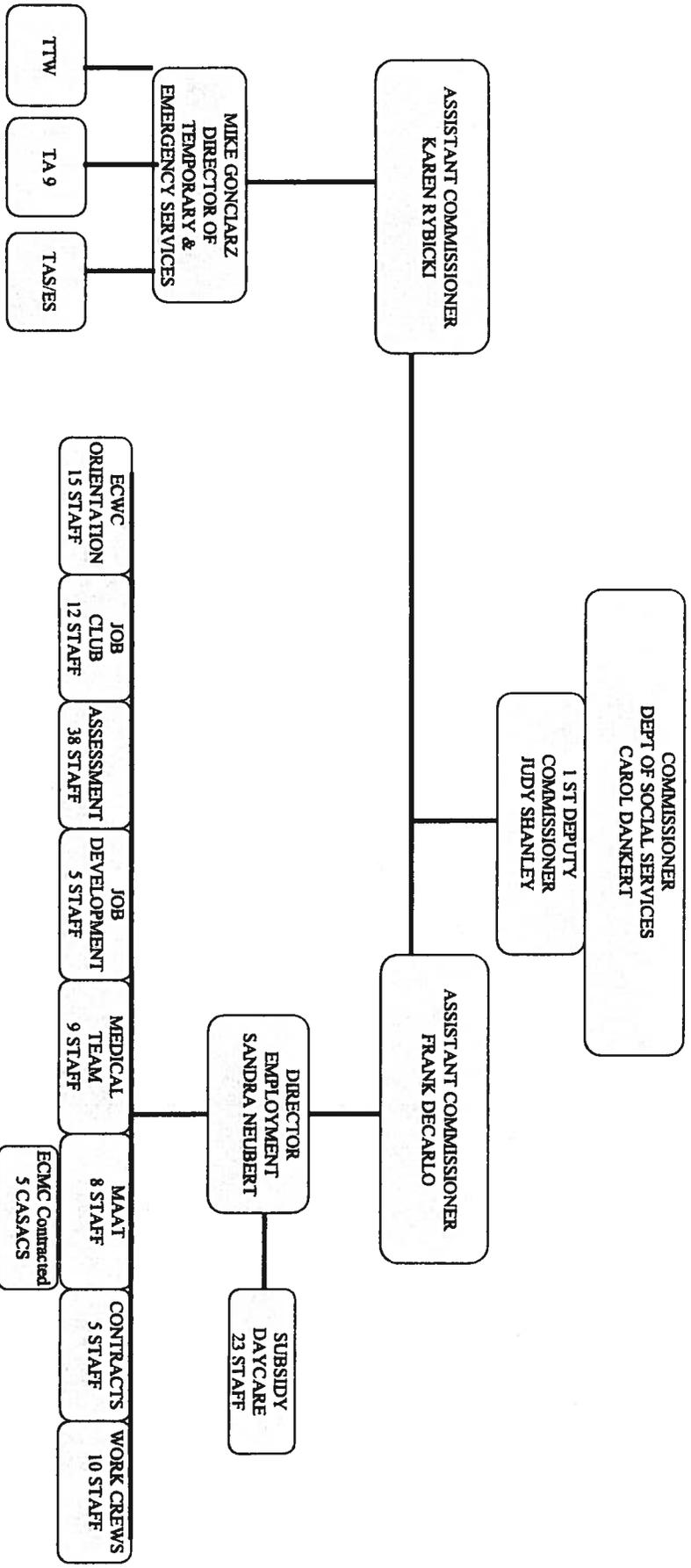


**Temporary Assistance and Food Stamps Employment Plan 1/1/14 –
12/31/15 – Attachment Pages**

- Attachment 1. Organizational Chart of Erie County Department of Comprehensive Employment**
- Attachment 2. Self Sufficiency Agreement Form (B4319)**
- Attachment 3. Employment Registration Agreement Form (B2341)**
- Attachment 4. Employment Orientation**
- Attachment 5. Applicant Job Search Activity Description**
- Attachment 6. Employability Assessment Tool (4 pages - a,b,c,d)**
- Attachment 7. Job Search Referral Form (B2342-A-2)**
- Attachment 8. Training Program Approval Letters
(3 pages B3854 Front & Reverse & B3854-A).**
- Attachment 9. Workfare Monthly Evaluation Calendar**
- Attachment 10. Medical Form LDSS-4526 For Employability Assessment,
Disability Screening and Alcoholism/Drug Addiction
Determination (2 pages – front/back)**



Contracted Agencies
 Buffalo Public Schools Adult Education Division
 Erie Community College-CAST
 Goodwill Industries of WNY
 Mental Health Peer Connection
 Salvation Army
 United Way WORKS

SELF-SUFFICIENCY AGREEMENT

The Erie County Department of Social Services will assist you to become an independent member of the community by developing a plan, with your contribution, that leads to self-sufficiency.

I agree to:

- help to come up with a plan for my employment
- look for a job and accept one if offered
- keep scheduled appointments
- call if unable to keep an appointment and attempt to reschedule
- go to training or vocational rehabilitation if required
- work in a Work Experience project if required

I understand that Public Assistance is temporary. If I don't take part in Employment activities, my application may be denied or my benefits may be reduced or stopped.

Signed _____ Date _____

The Agency agrees to:

- help you come up with a plan to make you self-sufficient
- offer services to help you find employment
- give you child care information
- assist you in obtaining child support
- answer any questions you may have regarding eligibility
- give you a chance to discuss any problems you have

The Agency will assist you in the agreed plan of activities which will lead you to self-sufficiency.

The Erie County Department of Social Services

Temporary (Cash) Assistance is subject to the following time limits:

- ❖ 5years (60 months) for families with children
- ❖ 2 years (24 months) for singles and childless couples

When these time limits end or if you are past the limits and are now applying for Temporary Assistance, you will be assessed or reassessed for eligibility for the Safety Net Non-Cash program.

Life Works If You Work Work Equals Independence

ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES
COMPREHENSIVE EMPLOYMENT DIVISION

EMPLOYMENT REGISTRATION AGREEMENT FORM

DUTIES OF A NON-EXEMPT PERSON

As a non-exempt person, you are expected to meet one or more of the requirements listed below as assigned by this Agency. The purpose of these requirements is to assist you in finding and keeping a job so that you will no longer be in need of public assistance.

If you are receiving Family Assistance, the law and regulations that allow us to do this are Title 9-B of the Social Services Law and 18NYCRR385.

If you are receiving Safety Net, the law and regulations that allow us to do this are Title 9-B of the Social Service Law and 18NYCRR385.

If you are only receiving Food Stamp Benefits, the law and regulations that allow us to do this are 18NYCRR385.

You must actively seek employment at all times and provide evidence of such activity if requested by the Social Services District.

You must report any and all employment obtained while receiving public assistance to your Social Welfare Examiner for proper budgeting.

You must participate in an initial assessment and in the preparation of an employability plan.

You must accept job referrals and/or any legal and suitable offer of employment.

You must provide medical verification and/or undergo a medical examination or other diagnostic assessment necessary for the purpose of determining any limitations to your employment activity.

You must participate in any work activity as assigned by the Social Service District.

ACKNOWLEDGMENT

I have read the above requirements, I understand them, and I agree to comply.

Signature of Applicant

Date

Signature of C.E.D. Worker

Date

Employment Orientation

ATTACHMENT # 4

- Erie County has a Work First policy.
- You must fulfill all work requirements.
- Employment counselors will evaluate your job skills and ability to work and will conduct a New York State drug and alcohol screening with you.
- As an applicant you will be assigned to a job search activity
- This will be a 3 week long supervised job search to help you find a job.
- If you do not find a job and your Temporary Assistance case opens, you will be placed in a Work Experience assignment.
- Work Experience provides participants with an opportunity to acquire the general skills, training, knowledge and work habits necessary to obtain and retain employment.
- You may be required by State and Federal Law to participate in work activities up to 40 hours a week to gain skills and experience.
- Your assignment will continue until you find a job or your case closes.
- Work Experience will assist you with child care and transportation so you can focus on finding a job.
- If you are medically able, you must find and keep a job.
- If medically unable to work, medical proof will be required.
- **If you do not comply with employment requirements, job search or the medical evaluation process your application may be denied.**
- **It is very important that you be early or on time for all appointments.** Failure to do so may result in the denial of your application. If denied, you will have to start the entire process again.
- You are responsible for the repayment of student financial aid.
- If your Temporary Assistance case opens, you may be eligible for remedial education or vocational training at no cost to you if you are approved.
- When you find a job and your Temporary Assistance case closes, you may be eligible for transitional child care.

Signature _____

APPLICANT JOB SEARCH ACTIVITY DESCRIPTION – 2013

- **Safety Net Accelerated Job Search (SN AJS)** is a three-week full time job search program designed to provide single Safety Net applicants with a meaningful job search activity. Employable Safety Net applicants are required to report on time each day to participate in the classroom segment which includes job search techniques, interviewing techniques and job keeping skills. A resume is done for each participant in AJS. Additionally, all applicants are registered with the NYS JOBS Program/ OTDA. Applicants are required to place 3 job applications per day during the first two weeks. Applicants are required to place 4 applications per day during the final week. Employment counselors closely monitor applicants' compliance with program requirements. Failure to comply results in the denial of the pending application. Upon completion of SN AJS, the applicants are scheduled for an assessment interview and Work Experience assignment to coincide with case opening at the employment division.
- **TANF Accelerated Job Search (TANF AJS)** was designed to provide TANF applicants who have a limited work history with a meaningful job search activity prior to case opening. Employable TANF applicants are required to report on time to three classroom sessions during a three week period. Job search techniques, tips for filling out applications, proper dress and hygiene and interviewing techniques are discussed. Additionally, all applicants are registered with the NYS JOBS Program/ OTDA. Applicants are required to make 12 applications during the three weeks of AJS. The employment counselors at AJS closely monitor applicants' compliance with program requirements. Failure to comply results in the denial of the pending application. Upon completion of TANF AJS, the applicants are scheduled for an assessment interview and Work Experience assignment to coincide with case opening at the employment division.
- **New York State JOBS Program – Office of Temporary and Disability Assistance (OTDA)** The JOBS program matches applicants with available jobs through job development activities and community resources. Applicants meet with NYS JOBS program staff 3 times over a three-week period. Applicant failure to follow-up with the referrals provided by the OTDA JOBS program or to report for the three scheduled appointments results in the denial of the pending application. Upon completion of this activity, the applicants are scheduled for an assessment interview and Work Experience assignment to coincide with case opening at the employment division.

APPLICANT JOB SEARCH ACTIVITY DESCRIPTION – 2013

- **Safety Net Recipients Job Club**

GOAL: To provide employable Safety Net recipients assistance in finding and keeping a job so they can become self-sufficient. The CED Assessment Unit will refer employable safety net recipients to the Safety Net Job Club as part of their required work activity for Temporary Assistance.

INFORMATION: The recipient Job Club, for single Safety Net clients, has been developed to provide a four week job search program which consists of both classroom instruction and the actual filing of employment applications. The program provides trained job search instructors, access to referral agencies and the many tools needed for the job search, including a resume and resources to find employers. The program provides transportation assistance so the client can focus on their job search and get to the maximum number of employers during the Job Club.

REFERRALS: Employment Counselors from the Assessment Unit will schedule and reassess employable Safety Net individual clients to determine if they are appropriate for Job Club.

SCHEDULE: Clients will report Monday, Tuesday and Thursday from 8:45 am – 11:45 am for four (4) weeks. Clients will be required to complete 3 employment applications per day.

RULES: If participants do not comply with Job Club program rules, the Assessment Counselor is notified, and the case may be conciliated and referred for sanction. Compliance to Job Club rules is mandatory; however, participants may provide written verification of any reason for good cause consideration.

Last revised 11/2013.

EMPLOYABILITY ASSESSMENT

GENERAL INFORMATION

First Name		M.I.	Last Name		Case Number	
Address				Change of Address		
City	ERIE	NY	Zip	CIN Number	Social Security Number	
Phone Number		Date of Birth	Sex	U.S. Cit. Y/N	Allen Reg. Number	Other Name Used
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER						
ETHNIC GROUP: <input type="checkbox"/> 1. WHITE - NOT OF HISPANIC ORIGIN <input type="checkbox"/> 2. BLACK - NOT OF HISPANIC ORIGIN <input type="checkbox"/> 3. HISPANIC <input type="checkbox"/> 4. AMERICAN INDIAN OR ALASKAN <input type="checkbox"/> 5. ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> OTHER						

EDUCATION

HIGH SCHOOL/GED	GRADE COMPLETED	SPECIAL EDUCATION	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1.				
2.		LEARNING DIFFICULTIES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
POST HIGH SCHOOL EDUCATION/TRAINING		COMPLETION DATE	DEGREES; CERTIFICATES	
1.				
2.				

EMPLOYMENT HISTORY (WORK HISTORY STARTING WITH LAST JOB)

DATES:	TITLE	HOURLY RATE OF PAY:	HOURS PER WEEK:
FROM: TO:			
JOB DUTIES:			
NAME OF FIRM		ADDRESS OF FIRM	
KIND OF BUSINESS			
REASON FOR LEAVING			
DATES:	TITLE	HOURLY RATE OF PAY:	HOURS PER WEEK:
FROM: TO:			
JOB DUTIES:			
NAME OF FIRM		ADDRESS OF FIRM	
KIND OF BUSINESS			
REASON FOR LEAVING:			
DATES:	TITLE	HOURLY RATE OF PAY:	HOURS PER WEEK:
FROM: TO:			
JOB DUTIES:			
NAME OF FIRM		ADDRESS OF FIRM	
KIND OF BUSINESS			
REASON FOR LEAVING			

TRANSPORTATION

TRANSPORTATION NEEDED TO GET TO JOB PUBLIC TRANSPORTATION AVAILABLE HAS OWN TRANSPORTATION AVAILABLE
 HAS A VALID DRIVER'S LICENSE (Type, Class, License Number) _____ STATE _____
 HAVE YOU EVER HAD YOUR DRIVER'S LICENSE REVOKED OR SUSPENDED FOR DWI? OTHER REASON? **PLEASE EXPLAIN:**

MILITARY

<input type="checkbox"/> VETERAN <input type="checkbox"/> NON-VETERAN <input type="checkbox"/> VIETNAM ERA SEPARATED <input type="checkbox"/> RECENTLY VETERAN	BRANCH	DATES OF SERVICE: FROM: TO:	TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> DISHONORABLE <input type="checkbox"/> OTHER THAN HONORABLE
MILITARY JOB TITLE:		TRAINING RECEIVED	
MILITARY DUTIES:			SERVICE RELATED DISABILITY _____%

CURRENT STATUS

NOW RECEIVING SERVICES FROM OTHER AGENCIES: COUNSELING SERVICES CRIMINAL JUSTICE FAMILY COURT PROBATION OMRDD TASA
 WORKER'S COMPENSATION TRAINING PROGRAMS MENTAL HEALTH CLINIC OVESID JTPA PEOPLE, INC.

OFFENDER STATUS

IF YOU HAVE EVER BEEN CONVICTED OF A CRIME, PLEASE EXPLAIN (include dates)	ARE YOU CURRENTLY ON <input type="checkbox"/> PROBATION or <input type="checkbox"/> PAROLE? DURATION: DO YOU HAVE A <input type="checkbox"/> CERTIFICATE OF RELEASE or <input type="checkbox"/> CERTIFICATE OF GOOD CONDUCT?
--	---

MEDICAL INFORMATION

IF YOU HAVE A DISABILITY OR CONDITION WHICH MAY INTERFERE WITH YOUR ABILITY TO WORK, PLEASE EXPLAIN:

IF YOU ARE NOW UNDER TREATMENT FOR ANY MENTAL OR PHYSICAL PROBLEM, PLEASE EXPLAIN:

<input type="checkbox"/> CURRENTLY UNDER A DOCTOR'S CARE Doctor's name, address, phone number	<input type="checkbox"/> TAKING MEDICATIONS REGULARLY (PLEASE LIST MEDICATIONS):
--	--

SPECIAL NEEDS OR ACCOMMODATIONS: WHEELCHAIR HEARING AID CANE/WALKER TTY ATTENDANT INTERPRETER

DO YOU PRESENTLY HAVE A PROBLEM WITH DRUGS OR ALCOHOL? YES _____ NO

IF YOU HAVE RECEIVED TREATMENT FOR DRUGS OR ALCOHOL, PLEASE DESCRIBE (include dates of treatment)
 INPATIENT OUTPATIENT TREATMENT COMPLETED

IS SUBSTANCE ABUSE TREATMENT REQUIRED FOR EMPLOYMENT? YES NO

WOULD YOU LIKE INFORMATION OR ASSISTANCE WITH OTHER PROBLEMS? (e.g.; FAMILY VIOLENCE) YES _____ NO

FAMILY

SERVICES RECEIVED: TANF SAFETY NET FOOD STAMPS SSI MEDICAID REFUGEE ASSISTANCE FOSTER CHILD OTHER

NAME OF ALL HOUSEHOLD MEMBERS	Date of Birth	SPECIAL NEEDS	OTHER INCOME (List Types)	SCHOOL SCHEDULE
1.				
2.				
3.				
4.				
5.				
6.				
7.				

DO YOU HAVE ORDERS FOR CHILD SUPPORT? YES NO

IS THERE A NON-CUSTODIAL PARENT OF YOUR CHILD/CHILDREN WHO WOULD BE INTERESTED IN WELFARE-TO-WORK PROGRAM? YES NO

SINGLE PARENT FAMILY TWO-PARENT FAMILY CO-OP FAMILY OTHER

COMMENTS:

CHILD CARE NEEDS

YOU REQUIRE CHILD CARE TO OBTAIN AND/OR RETAIN EMPLOYMENT
 YOU DO NOT HAVE CHILD CARE OR HAVE SERIOUS PROBLEMS WITH YOUR CURRENT CHILD CARE ARRANGEMENTS
 YOU WISH ASSISTANCE IN LOCATING AND ARRANGING CHILD CARE. CHILD CARE COALITION: 884-9126

IF YOU HAVE CHILD CARE ARRANGEMENTS, PLEASE DESCRIBE: _____

SKILLS

READING/LITERACY LEVEL _____ TEST USED _____ DATE _____

MATH LEVEL _____ TEST USED _____ DATE _____

NATIVE LANGUAGE _____

OTHER: _____

CLIENT SKILLS: _____

KIND OF WORK DESIRED: _____

WHY? _____

LIST TOOLS YOU HAVE THAT RELATE TO YOUR JOB SKILLS: _____

LIST EQUIPMENT YOU CAN OPERATE (OFFICE, MECHANICAL, PRODUCTION, ETC.): _____

CIRCUMSTANCES IMPACTING EMPLOYMENT

BARRIERS IMPACTING EMPLOYMENT: _____

STEPS TO OVERCOME BARRIERS:

1. _____

2. _____

3. _____

4. _____

5. _____

WELFARE TO WORK CRITERIA (CHECK ALL THAT APPLY ON EACH LINE)

A.	B.	C.	D.
<input type="checkbox"/> DROPPED OUT OF SCHOOL <input type="checkbox"/> TEENAGE PREGNANCY <input type="checkbox"/> POOR WORK HISTORY <input type="checkbox"/> DISABILITY	<input type="checkbox"/> TANF RECIPIENT - LESS THAN 30 MONTHS	<input type="checkbox"/> LONG TERM TANF RECIPIENT - IN EXCESS OF 30 MONTHS	<input type="checkbox"/> NON H.S. GRAD WITH LOW READING OR MATH SKILLS <input type="checkbox"/> POOR WORK HISTORY <input type="checkbox"/> REQUIRES SUBSTANCE ABUSE TREATMENT

COMPLETE TTW ELIGIBILITY FORM IF EITHER: (1) ANY BOX IS CHECKED IN "A" COMBINED WITH BOX B OR C. (2) "C" BOX IS CHECKED COMBINED WITH TWO BOXES IN "D".

EMPLOYMENT PLAN

CLIENT EMPLOYMENT PREFERENCES:
1.
2.
3.
SHORT TERM STEPS TO REACH GOALS:
1.
2.
3.
CLIENT RESPONSIBILITIES:
1.
2.
3.
ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES RESPONSIBILITIES:
1.
2.
3.
CHANGES TO GOALS:
1.
2.
3.

SUPPORTIVE SERVICES PLAN: Include day care for children, clothing, day care for adults, transportation, license and other fees, job-related safety equipment, counseling and services for family members, where appropriate. Erie County Dept. Of Social Services Responsibility: Guaranteed child care subsidy provided to parents in receipt of financial assistance with child(ren) under 13 years of age, if necessary to enable parent to work or participate in work training activities.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that if I do not agree with this plan, I may have a conference with my employment worker and with an impartial person who will try to help my worker and me resolve our differences about what should be in my plan. I certify that I have received a true and exact copy of this form. I have been involved in the development of the above plan and I understand that it is my responsibility to follow through with the activities to the best of my ability. I understand that information regarding medical limitations may be shared with a Vocational or a Work Experience Program.

1.	
Participant's Signature	Date
2.	
Participant's Signature	Date
3.	
Participant's Signature	Date
4.	
Participant's Signature	Date

1.	
Employment Advisor's Signature	Date
2.	
Employment Advisor's Signature	Date
3.	
Employment Advisor's Signature	Date
4.	
Employment Advisor's Signature	Date

ERIE COUNTY COMPREHENSIVE EMPLOYMENT DIVISION

() 290 Main Street, Room _____

() 158 Pearl Street, Room _____

Buffalo, New York 14202

THIS WILL INTRODUCE: _____

APPLYING FOR POSITION OF: _____

TO SEE: _____

NAME OF COMPANY/AGENCY: _____

ADDRESS: _____

DATE: _____ TIME: _____

APPLICANT ELIGIBLE FOR:

- () **TEAP ON-THE-JOB TRAINING** (Training and employment assistance program)
- () **PIVOT** (placing individuals in vital opportunity training)
- () **InVEST** (individual vocational education and skills training)
- () **WOTC** (work opportunity tax credit)

REFERRED BY EMPLOYMENT COUNSELOR: _____

TELEPHONE NUMBER: _____ DATE: _____

* * * * *

TO BE FILLED OUT AND RETURNED BY EMPLOYER

APPLICANT'S NAME: _____

COMPANY/AGENCY: _____

() HIRED STARTING DATE: _____

() NOT HIRED REASON: _____

() DID NOT REPORT FOR INTERVIEW ON DATE: _____

HIRING OFFICIAL: _____ DATE: _____

() WOTC VOUCHER COMPLETED AND SENT TO NYSDOL

EMPLOYMENT COUNSELOR: _____

ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES
EMPLOYMENT COMPLEX
290 MAIN ST. - 5th FLOOR
BUFFALO, NEW YORK 14202

ATTACHMENT #8
FRONT

- () Date
() Case Number
() Category

Dear Recipient:

The training program you are enrolled in at _____
[] Has been **Denied** - Reason _____
[] Has been **Approved** from _____ to _____

- [] You will be receiving a TANF Employment Related Training allowance for this period. It is to assist you in meeting your educational and/or training needs.
[] You will receive a once-only allowance of \$ _____ to cover the period _____ to _____
(Please allow at least 10 days for processing)
[] You will receive a recurring, semi-monthly allowance of \$ _____
to cover the period _____ to _____
This allowance is for: [] Lunch [] Transportation [] Other _____
[] You will **not** receive an employment related training allowance because:
[] Grant information incomplete on B-1383
[] No schedule submitted
[] Grants exceed costs of tuition fees, books and supplies
[] Other _____

REMINDERS

- Each semester or session you must provide this office with the following:
(A) Verification of enrollment and financial aid (B-1383).
(B) An official copy of your school schedule showing your hours.
(C) A copy of your report card or transcript.
- Your monthly attendance must be 100% according to TANF regulations. If your attendance falls below this point for any given month you will be required to provide a valid excuse for the poor attendance **or** face possible sanction procedures. This can result in a loss of or reduction in your Public Assistance.
- When you leave or complete the program you will need to contact your employment counselor and provide:
(A) Date and reason for leaving if you did not complete the program requirements.
(B) A copy of your certification, diploma or degree.

If you have any question regarding your allowance, or the TANF Program requirements, please call *your* Employment Counselor at 858-_____.

Sincerely,

Employment Counselor

NAME:	ADDRESS:	CASE NUMBER:
-------	----------	--------------

FOOD STAMP IMPLICATIONS: This notice applies only to your requirement to participate in temporary assistance work activities. You may or may not be required to participate in Food Stamp Employment and Training (FSET) activities. You were notified of the Food Stamp employment responsibilities and exemptions in the LDSS-4148A: *What You Should Know About Your Rights and Responsibilities, Book 1*. If you have any questions about your Food Stamp employment requirements, ask your worker.

CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

If you think our decision was wrong, you can ask for a review of our decision. If we made a mistake, we will correct it. You can do both 1 and 2:

1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer.
1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of this notice. Sometimes this is the fastest way to solve any problem you may have. **If you ask for a conference you are still entitled to a fair hearing. If you do not want to have to comply with work requirements until a fair hearing decision is issued, you must request a fair hearing in the way described below. A request for a conference alone will not remove your requirement to participate in work activities.**
 2. **STATE FAIR HEARING – YOU HAVE 10 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING IF YOU HAVE BEEN DETERMINED TO BE EXEMPT BECAUSE YOU ARE UNABLE TO WORK DUE TO A MEDICAL CONDITION (IF PART 1 IS CHECKED). YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING IF YOU HAVE BEEN DETERMINED TO BE EXEMPT FOR A NONMEDICAL REASON (IF PART 2 IS CHECKED).**

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by mail, by phone, by fax or online.

Mail: Send a copy of this notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

- Phone:** 800-342-3334 (Please have this notice with you when you call.)
- Fax:** Fax a copy of the front and reverse of this notice to: (518) 473-6735 or
- Online:** Complete an online request form at: <http://www.otda.state.ny.us/oah/forms.asp>.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax or online, please write to ask for a fair hearing before the deadline.

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice that tells you when and where the fair hearing will be held. At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing. At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong.

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements. At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

LEGAL ASSISTANCE: If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your Yellow Pages under "Lawyers".

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call, write or fax to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the front of this notice or write to us at the address on the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the front of this notice or write to us at the address on the front of this notice.



County of Erie

MARK C. POLONCARZ
COUNTY EXECUTIVE

DEPARTMENT OF SOCIAL SERVICES

_____/_____/_____

COMPREHENSIVE EMPLOYMENT DIVISION

Dear _____:

You will be receiving an **Employment Related Training Allowance** in the amount of \$_____. This allowance covers the time period from: _____ through: _____. (Please allow 10 days for processing.)

This allowance is for:

- Transportation
- Special Needs/Other (specify below)

Effective _____ through _____, your Financial Assistance Worker will continue your allowance money at \$_____ per month.

Please note: It is recommended that you purchase a monthly bus pass with the transportation allowance.

If you have any questions regarding the amount of allowance you will receive or the time period for which you will receive the allowance, please call your Employment Worker at _____.

Sincerely,

Employment Worker

DECEMBER 2013

Attachment #9

NAME _____ PHONE# _____ SITE _____
 SUPERVISOR _____ PHONE # _____ CED WKR _____ PHONE# 858-_____
 WCLY HRS: WORK EXPERIENCE _____ VOCATIONAL TRAINING _____ EDUCATIONAL TRAINING _____ JOB SKILLS TRAINING _____

KEY: H = Holiday* Ex. H-6 EA = Excused Absence - Attach verification to report.	Terminated: _____ YES _____ NO _____ Date Terminated _____ (Explain in remarks)
--	--

START DATE: _____ SHIFT START: _____ END: _____

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		TOTAL WEEKLY HOURS		
	WEVT	ED/JST	WEVT	ED/JST	WEVT	ED/JST	WEVT	ED/JST	WEVT	ED/JST	WEVT	ED/JST	TOTAL
11/25			11/26		11/27		11/28		11/29				
12/2			12/3		12/4		12/5		12/6				
12/9			12/10		12/11		12/12		12/13				
12/16			12/17		12/18		12/19		12/20				
12/23			12/24		12/25		12/26		12/27				
12/30			12/31		1/1		1/2		1/3				

EVALUATION: A. EXCELLENT B. AVERAGE C. BELOW AVERAGE

REMARKS: _____ MONTHLY TOTAL _____

EMPLOYMENT: _____
 TASKS PERFORMED THIS MONTH: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____
 PLEASE DELIVER OR FAX THIS REPORT TO TERRY WEAVER AT 858-1065 NO LATER THAN THE 5TH OF EACH MONTH B3683 (11/08)

MEDICAL EXAMINATION FOR EMPLOYABILITY ASSESSMENT, DISABILITY SCREENING, AND ALCOHOLISM/DRUG ADDICTION DETERMINATION

I. CLIENT IDENTIFICATION

Print Client Name: _____ Veteran: Yes No

Address: _____

Case #: _____ CIN: _____ DOB: _____

Reason(s) for referral: Client states that: _____

II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining physician to disclose to the Department of Social Services any information provided, any diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that this information will be treated as confidential.

Client Signature x _____ Date: _____

AUTORIZACION PARA DAR A CONOCER INFORMACION MEDICA

Yo autorizo al médico que me está examinando a dar a conocer al Departamento de Servicios Sociales cualquier información provista, cualquier diagnosis, condiciones reveladas y limitaciones funcionales identificadas en base al examen realizado. Comprendo que esta información será confidencial.

Firma del Cliente x _____ Fecha: _____

III. MEDICAL INFORMATION

List All Medical Conditions. Include psychiatric and alcohol/drug addiction diagnosis using DSM-IV format. (List all medical diagnoses and specify medical/clinical findings, including prognoses and how long each condition is expected to last.)

Medical Condition	Prognosis and Treatment Recommendations including prescribed medications	Date of original diagnosis/diagnosis type	Expected Duration From Present (Months)
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent

IV. FUNCTIONAL LIMITATIONS (related to medical findings noted in Section III): (check column that applies)

a.) Physical Functioning	No. Evidence of Limitations	Moderately Limited	Very Limited	b.) Mental Functioning	No. Evidence of Limitations	Moderately Limited	Very Limited
Walking				Understands and remembers instructions			
Standing				Carries out instructions			
Sitting				Maintains attention/concentration			
Lifting, Carrying				Makes simple decisions			
Pushing, Pulling, Bending				Interacts appropriately with others			
Seeing, Hearing, Speaking				Maintains socially appropriate behavior without exhibiting behavior extremes			
Using Hands				Maintains basic standards of personal hygiene and grooming			
Stairs or other climbing				Appears able to function in a work setting at a consistent pace			
Other:				Other:			

V. TREATMENT HISTORY (list for medical, psychiatric, alcoholism and drug treatment for the past Two Years)

Name of Program/Provider	Type of Program/Provider i.e. Outpatient, Residential, Methadone (for addiction specify modality)	Length of Treatment (# of Months)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. CURRENT TREATMENT PROGRAM IDENTIFICATION (include medical, psychiatric, alcoholism and drug treatment as applicable.)

Program Name: _____
 Address of Client's Treatment Site: _____
 Mailing Address (if different from above): _____
 Treatment Program Contact: _____ Title: _____
 Telephone #: () _____ Fax #: () _____

VII. LIMITATIONS ON WORK ACTIVITIES

a. Taking into consideration physical, mental and addiction limitation(s), describe any working conditions, environments, or work activities which are contraindicated: _____

b. Are these restrictions expected to last: 1-3 months 4-6 months 7-11 months 12+ months permanent

c. Do you recommend referral to rehabilitation, including but not limited to, a mental health or alcohol/substance abuse, or a physical rehabilitation program? Yes No If yes, please specify: _____

VIII. SCREENING FOR POSSIBLE SSI REFERRAL

Based on the evidence available to you, does this individual have severe impairment(s) which has lasted, or is expected to last at least 12 months? IF YES, please check _____ Explain briefly: _____
 _____ If substance abuse is also found, would such impairment be expected to continue if use of drugs and/or alcohol were to cease? Yes No

IX. PHYSICIAN INFORMATION

Physician's or Psychologist's Name (please print): _____
 Address: _____
 Board eligible or certified specialty: _____ Tele.#: () _____ Fax #: () _____
 Is this client a patient of the examining physician? Yes No If yes, for how long? _____
 Date of Last Examination: _____
 Signature of physician or psychologist: X _____ Date: _____

Please forward this completed form to Social Services Contact: _____
 Telephone #: _____ Address: _____