Central Wisconsin Community Action Council, Inc.

1000 Hwy 13
P. O. Box 430
Wisconsin Dells, WI 53965

Phone: 608.432.4359
Fax: 608.742.0984
Email: lynette@cwcac.org

Thank you for your interest in our Skills Programs offered by CWCAC, Enhanced Skills Program and Nursing Skills Program. The following information will help you decide which program suits you best in choosing your new career. Please check the box next to the program you will be submitting your application for and return with your application.

Household Size	Annual	Hourly
1	$21,870.00	$10.51
2	$29,580.00	$14.22
3	$37,290.00	$17.93
4	$45,000.00	$21.63
5	$52,710.00	$25.34
6	$60,420.00	$29.05
7	$68,130.00	$32.75
8	$75,840.00	$36.46

❑ **Enhanced Skills Program (At or Below 150% Poverty Level):**

This program is for short-term certificate programs such as Certified Nursing Assistant, Phlebotomy, HVAC Technician, Welder, EMT, Massage Therapist, Personal Trainer, etc.

We will work with eligible participants during the year to identify training goals that will result in an increase in their annual income, by increasing their hourly wage, increasing the number of hours worked weekly and accessing employer- sponsored health insurance.

- Must be 18 or older
- Must be at or below 150% of poverty
- Must be employed minimum of 20 hours/week and MAINTAIN employment during training
- Must work with the Job Skills Coach on developing a training plan
- Must apply for financial aid or other programs for which they may be eligible
- Must maintain residence in Wisconsin

Central Wisconsin Community Action Council, Inc.

1000 Hwy 13
P. O. Box 430
Wisconsin Dells, WI 53965

Phone: 608.432.4359
Fax: 608.742.0984
Email: lynette@cwcac.org

❑ NURSING SKILLS PROGRAM (At or Below 80% CMI):

This program is for individuals who are looking for careers in the medical field such as CNA, LPN, Medical Assistant, Associated Degree Nurse, and RN.

This program is to increase the healthcare workforce in the State by offering under-employed and unemployed, love- and moderate-income individuals with opportunities to receive education/training in an entry-level healthcare field.

- Must be 18 or older
- Must be at or below 80% County Median Income (CMI)
- Must complete course of study or training and be eligible to work in the profession by June 30, 2025
- Must live in one of the participating 5 counties: Sauk, Columbia, Juneau, Adams & Dodge
- Must maintain residence in Wisconsin

Household Size	80% CMI Sauk	80% CMI Columbia	80% CMI Juneau	80% CMI Adams	80% CMI Dodge
1	$4,062.50	$4,570.83	$3,966.66	$3,966.66	$4,029.16
2	$4,641.66	$5,220.83	$4,533.33	$4,533.33	$4,604.16
3	$5,220.83	$5,875.00	$5,100.00	$5,100.00	$5,179.16
4	$5,800.00	$6,525.00	$5,666.66	$5,666.66	$5,754.16
5	$6,266.66	$7,050.00	$6,120.83	$6,120.83	$6,216.66
6	$6,729.16	$7,570.83	$6,575.00	$6,575.00	$6,675.00
7	$7,195.83	$8,091.66	$7,029.16	$7,029.16	$7,137.50
8	$7,658.33	$8,616.66	$7,483.33	$7,483.33	$7,595.83

If you have any questions while filling out your application, please feel free to contact me at 608.432.4359 and I will be happy to assist you.

With regards,

Lynette

Lynette Ives
Skills Enhancement Program Manager

AN EQUAL OPPORTUNITY PROVIDER

Central Wisconsin Community Action Council, Inc.

Administrative Office
1000 Hwy 13
P. O. Box 430
Wisconsin Dells, WI 53965

Phone: 608.432.4359
Fax: 608.742.0984
Email: lynette@cwcac.org

ENHANCED SKILLS & NURSING SKILLS PROGRAM APPLICATION

All information is confidential

Please check the box next to the program you are applying:

❑ **Enhanced Skills Program (150% Poverty Level)** ❑ **NURSING SKILLS PROGRAM (80% CMI)**

PERSONAL INFORMATION

PLEASE DO NOT WRITE IN SHADED AREAS				Entry Date:
Social Security Number	**Last Name**		**First Name**	
Mailing Street Address or PO Box	**City**	**State**	**Zip code**	**County of Residence**
Street Address ***(if different)***				
Home Telephone Number	**Work Telephone Number**		**Cell Phone Number**	
Email Address:			Date of Birth **(mo/day/year)**	
Gender ❑ Male ❑ Female	**U. S. Citizen** ❑ Yes ❑ No	**If not a US Citizen, are you a Qualified Alien?** ❑ Yes ❑ No	**Alien Registration No.**	
How many people live in your household (include yourself)?				
How many children do you support?	**Does the child(ren) live with you?** ❑ Yes ❑ No			
Household Composition (check one that best describes your family) ❑ Single ❑ Two Parent ❑ Single Female Parent ❑ Single Male Parent ❑ Two Adults/No Children				
Marital Status (check one that best describes your status) ❑ Single ❑ Unmarried living with Partner ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other				
Race (Optional) ❑ Alaskan Native ❑ American Indian ❑ Asian/Pacific Islander ❑ Black ❑ Hispanic ❑ White ❑ Other (please specify) _____				

For Office Use Only: _____

FAMILY INCOME: List All Family Members Income

PART 1 - INCOME FROM EMPLOYMENT (Including Self-Employment Income)

FAMILY MEMBER NAME	EMPLOYER	WEEKLY HOURS	MONTHLY GROSS INCOME
1. Self			
2.			
3.			
PART 1 TOTAL - Add Lines 1 through 3			$

Employer's Phone Number	Employer's Address	Hire Date	Health Care Benefits? ❑ Yes ❑ No

Current Job Title	Hourly Wage $	Previous Occupation	Veteran? ❑ Yes ❑ No
			MF SF

PART 2 - UNEARNED INCOME FROM: Child Support, Alimony, SSI, SSDI, Inheritance, Retirement, Interest, Education Grants/Scholarships, Charity, etc.

FAMILY MEMBER NAME	SOURCE	AMOUNT PER MONTH
1.		
2.		
3.		
PART 2 TOTAL - Add Lines 1 through 3		$
ADD PART 1 and PART 2 TOTALS		$
DEDUCT MONTHLY CHILD SUPPORT PAYMENTS MADE BY YOU OR SPOUSE		$
ADJUSTED MONTHLY HOUSEHOLD INCOME		

Is your family receiving (Check all that apply): ❑ **AFDC** ❑ **W2** ❑ **Food Stamps**
❑ **WIC** ☒ **BadgerCare** ❑ **Childcare** ❑ **Medical Assistance**
❑ **Other Public Assistance? (Please List:) _____**

Do not write in this area

Would you like to receive information about these programs? ❑ **Yes** ❑ **No**

EDUCATION

What is the highest grade you have completed? ❑ 0th ❑ 11th ❑ 12th ❑ 13th ❑ 14th ❑ 16th ❑ Masters ❑ Doctorate

Do you have a G.E.D., H.S.E.D., or high school diploma? ❑ Yes ❑ No **Date Completed:** _____

Do you have vocational, college, or specialized training? ❑ Yes ❑ No

- If **YES**, Area of training _____

  How much have you completed? _____

- If **NO**, are you interested in: ❑ G.E.D. or H.S.E.D. programs
  ❑ Vocational or Special training
  ❑ College
  ❑ Other

Are you enrolled (or plan to enroll) in an educational program? ❑ Yes ❑ No

- If **YES:** Name of school: _____ Name of program: _____

  Will you (or have you) be applying for financial aid? ❑ Yes ❑ No - **If NO, explain**: _____

_____

CAREER GOALS

Have you defaulted on past student loans? ❑ Yes ❑ No - **If YES, how much do you owe?** _____

What is your career plan? _____

Projected Graduation Date: _____

Testing Completed:

Test Name	❑ *Goal Testing*	❑ *Accuplacer*	❑ *Career Inventory*	❑ *TABE*	❑ *ESL*
Date completed					

CHILD CARE

Who referred you the Skills Enhancement Program? _____

Do you have reliable childcare? ❑ No ❑ Yes - **Provided by whom?** _____

Do you receive County assistance for childcare? ❑ Yes ❑ No

TO BE SIGNED IN THE PRESENCE OF AGENCY REPRESENTATIVE

I certify that the information on this application is a true and complete statement of facts according to my best knowledge and belief. I further certify that I have read and understand the statements on this page and agree to them. I also understand that I may be asked to provide proof of any information given on this application form.

_____ _____

Signature of Applicant *Date*

Central Wisconsin Community Action Council, Inc.

Administrative Office
1000 Hwy 13
P. O. Box 430
Wisconsin Dells, WI 53965

Phone: 608.432.4359
Fax: 608.742.0984
Email: lynette@cwcac.org

CWCAC is WORKING

AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

(In order for you to be considered for this program, it will be necessary for you to sign a release of information form. The reason for this is to verify residency, citizenship, employment status, income and any other sources of income or assistance.)

I authorize any federal, state or local agency, organization, business, or individual to release to Central WI Community Action Council, Inc. information needed to complete and verify my application for participation and/or to maintain my continued assistance in CWCAC's Skills Enhancement program. I understand and agree that this Authorization for the information obtained may be given to and used in administering and enforcing rules and policies.

NAME: _____ D.O.B.: _____

SOCIAL SECURITY NUMBER: _____

AGENCY DESIGNATED TO RELEASE/EXCHANGE INFORMATION: *For Office Use*

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

I understand that I have the right to inspect and receive a copy of the material disclosed and a copy of this consent form. I also understand this consent form is revocable, however, information may be released before receipt of written notice of revocation.

Participant Signature Date

CWCAC, Inc. Skills Enhancement Mgr. Signature Date

This consent for Release of Information will expire upon: (specify date, event or condition when it will expire)

EVENT/DATE/CONDITION: _____

Central Wisconsin Community Action Council, Inc.

Administrative Office
1000 Hwy 13
P. O. Box 430
Wisconsin Dells, WI 53965

Phone: 608.432.4359
Fax: 608.742.0984
Email: lynette@cwcac.org

Skills Enhancement Program Applicant
Employment Information Sheet

Name: _____ **Date of Birth:** _____

Employer: _____ **Phone:** _____

Mailing Address: _____

City/State/Zip: _____

Position/Job Title: _____ **Start Date:** _____

Hourly Wage: _____ **Hours per Week:** _____

Check those items that apply to the job and / or you:

- ☐ **Insurance Paid in Full by Employer**
- ☐ **Group Rate Insurance, Employee Pays 100%**
- ☐ **No Insurance Benefits Available**
- ☐ **Employee Paid Insurance Option – Employee Declined**
- ☐ **Co-Pay Insurance, Employee Pays Part**
- ☐ **Co-Pay Insurance Option – Employee Declined**
- ☐ **Insurance Available Within Six Months of Job**

Signature: _____ **Date:** _____

Media Release Form

Central Wisconsin Community Action Council (CWCAC) requests your written consent to use your and/or your child's image, likeness, voice and/or story in photos, videos and other media in various print and online publications and publicity.

You are NOT REQUIRED to give this consent in order to participate in CWCAC programs or receive services or benefits from or through CWCAC.

Please provide the information below and indicate whether you do or do not consent to this use.

☐ I am 18 years of age or older and am signing this form on my own behalf.

AND/OR

☐ I am the parent or legal guardian of the child or children named below, who are under 18, and I am signing this form on behalf of my child or children listed below.

Your Name (Print Full Name) _____

Child/Children Name(s) (Print Full Name) _____

Address (number, street, and apt. or suite no.) _____

City, State, and ZIP code _____

Phone Number Email _____

A. I DO consent to use.

I grant CWCAC permission for noncommercial use of my and/or my child's image, likeness, voice, and/or story in media of all types in perpetuity without further authorization from me.

I understand such uses include but are not limited to brochures, fund-raising letters, posters, annual reports, website, social media and YouTube.

I submit my and/or my child's image, likeness, voice, and/or story voluntarily and understand I will receive no payment, royalties or other compensation or consideration.

I understand CWCAC may share my and/or my child's story, image, likeness, and voice with its partners, funders and news media and that further dissemination may occasionally be beyond CWCAC's immediate control.

I release CWCAC from and against any and all claims which I, my heirs or representatives have or may have by reason of this authorization or the use of my and/or my child's story, image, likeness, and voice.

☐ I have read this release before signing below, and I fully understand the contents, meaning and impact of this release, and consent to all the conditions above.

Signature _____ Date _____

B. I DO NOT consent to use.

I do not want CWCAC to use the image or voice of me and/or my child or children in publications or media and do not consent to such use.

Signature _____ Date _____

Direct any questions to Lynette Ives, Skills Enhancement Manager at 608-432-4359 or lynette@cwcac.org

Transforming People and Communities

SKILLS ENHANCEMENT PROGRAM AGREEMENT

Welcome to Central Wisconsin Community Action Councils' Skills Enhancement Program. CWCAC is a community action agency whose mission is to transform people and communities to advance social and economic justice.

In order for CWCAC to provide services to program participants in an effective and efficient manner, we need all participants to follow through with the following program expectations:

1. Continue working for a minimum of 20 hours per week.

2. Provide requested documentation (i.e. income verification, class schedules, copy of grades, receipts for pre-approved reimbursements, copies of financial aid letters, scholarship awards and other pertinent documents) in a timely manner.

3. Keep in contact with your Skills Development worker ***at least once per month*** to update them on progress and/or areas of concern. We need you to let us know when your situation changes (such as job changes, increase/decrease in hours/salary, new address or phone number, change in people in the household, change in school or degree program, added or dropped classes, etc.) Due to the limited number of program slots, your file can be closed if you have not contacted us within 6 months.

4. We need you to respond to phone calls/letters/emails from our office staff. There are times when funding sources require us to submit program progress reports, therefore we need your cooperation in providing us with the requested information.

5. Due to the limited amount of funding available, we have maximum guidelines for funding towards tuition, books/program related supplies. The maximum for tuition, books/supplies is $1200.00 per semester. These guidelines are subject to change based on funding received for the program. Please note that funding is approved each semester based on need and status in the program.

6. Upon completion of the Skills Enhancement Program, verification of employment, wage/salary, and benefits offered must be submitted (check stub or offer letter).

7. Our Funding sources require information regarding the follow-up status of program participants therefore; you will be contacted at least three times within the nine months following the completion of your program in order to access employment status, wages and benefits.

I agree with the above program expectations.

_____ _____

Signature Date

_____ _____

Staff Signature Date