



2021 Summer Youth Employment Program (SYEP) Application

Orleans County Job Development Agency



What do we mean by eligible?

- Applicants must be Orleans County residents between age 14 and 20 AND
- Household income within eligibility range. See chart.
- Applicants in foster care or households that receive cash assistance, Medicaid, HEAP, SSI, and SNAP are automatically eligible



When are applications due?

Priority for job placements will be given to applications received by April 30th. Applications received after April 30th will be accepted on an ongoing basis until May 31st or until all spots have been filled.

Family Size	Yearly Income
1	\$25,760
2	\$34,840
3	\$43,920
4	\$53,000
5	\$62,080
6	\$71,160
7	\$80,240
8	\$89,320



Where do I send my application?

Orleans County Job Development Agency
14016 Route 31 West
Albion, NY 14411
Fax to 585-589-2795

or you can put in **C.O.B.** drop box at the Main Entrance of the County Building



Who do I contact if I have more questions?

Peter Anderson, call or text: 716-387-4081

Email: OCSYEP@orleansny.com or Visit website: Orleansny.com/jobdevelopment



What happens next?

If you appear eligible for the program, you will be contacted by the Youth Counselor or a Program Assistant to set up your interview. If you are under 18 a parent or guardian **MUST** sign your application and attend the interview with you.

Submitting a completed application does not guarantee selection into the program or work site placement.

A proud partner of the



Orleans County Job Development Agency Summer Youth Employment Program (SYEP)

List of Documents Required for Eligibility Interview

****Any applicant under 18 years old must have a parent/guardian attend the interview**

1. Income Documents – You need to check one of these boxes

☐ You are automatically income eligible if you get cash assistance, **SNAP, Medicaid, HEAP, SSI** or if in **foster care**. Please provide award letter as proof.

OR

☐ If you don't have any of the above, you will need proof of all family members income for the past 26 weeks (6 months). That can include:

- o Employment – most recent paycheck (stub) with year to date total
- o Copy of social security check, award letter, or bank statement showing deposit
- o Retirement income statement, check, or bank statement
- o Unemployment Insurance – determination letter or payment history print out
- o Copy of child support and/or alimony check, a signed note from paying parent that states the total amount or form from Support Collection Unit
- o Statement of Self-Employment income showing income and expenses

AND

2. Identification and citizenship documents –items below:

<p>One of the following:</p> <ul style="list-style-type: none"> ○ Birth Certificate ○ Driver License or Learner Permit ○ Work Permit may also be used if above unavailable  <p>Or</p>  <p>Or</p> 	<p>One of the following:</p> <ul style="list-style-type: none"> ○ Birth Certificate ○ Passport ○ Public Assistance/Food Stamp records  <p>Or</p>  <p>Or</p> 	<p>And Signed Social Security Card</p>  <p>And a Photo ID Driver License, benefit card with photo, school ID <i>current school year</i> (ex. 2013-2014), Sheriff ID, Safe Kids Card</p>  <p>And Selective Service required for males over 18 www.sss.gov</p>	<p>And Original Work Permit (if under 18) and please note: a new permit will be needed if turning 16</p>  <p>And Report Card most recent</p> 
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TANF YOUTH SERVICES APPLICATION

The information requested on this form is necessary to determine whether or not federal Temporary Assistance for Needy Families (TANF) funds may be used to provide services to you. This application form may be used by an applicant for services who is under 21 years of age.

SECTION ONE

A. Information About the Youth Applicant

1. Applicant's Name: _____

Home Address: _____
(Street) (Apartment Number)

(City) (State) (Zip Code)

Social Security Number: _____

Date of Birth: _____
(Month, Day, Year)

Telephone Number: _____

SECTION TWO Citizen / Non-Citizen Status

A. Are you a United States citizen?

- ☐ **Yes.** If yes, **go to** Section Three.
☐ **No.** If no, complete Item B.

B. If you (the youth applicant) are not a United States citizen, look at the "Immigration Status List" on pages 5 and 6 and tell us which status applies to you. Enter the status number from the list and complete the information below.

Immigration status (# 1 through 15) that applies: _____

INS Form Number: _____

Alien Number: _____

Date of Entry into United States: _____

SECTION THREE Income of Family Members

A. Do you (the youth applicant) currently receive benefits under one or more of these programs?

- ☐ **Yes,** check which program(s) and then **go to** Section Four.

FAMILY ASSISTANCE/ SAFETY NET	MEDICAID	SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)	HEAP	SSI

- ☐ **No,** complete Item B, on page 2.



B. If you do not currently receive one of the programs listed above, please tell us about any income of your family members.

Include the gross income (income before taxes and deductions) of each family member who lives with you. Family members include your mother, father, stepmother, stepfather, any brothers or sisters (including half-siblings) who are under 18 years of age (or 18 and in secondary school) and these siblings' parents. If you have a child of your own, you should include that child, any brothers or sisters of the child, and the child's parent. You should not include any of these people if they do not live with you. You should not include other family members such as grandparents, uncles or aunts. If you are married, you should include your spouse, but do not need to include your parents or siblings.

List all sources of gross income, including wages, social security benefits, public assistance benefits, child support, alimony, etc. received and any other recurring income of a family member. You do not need to include any earned income (wages) received by you or any other family member who is under 18 years of age (or 18 and in secondary school) but must include any unearned income.

	NAME	INCOME SOURCE: WAGES, SOCIAL SECURITY, etc.	AMOUNT	RECEIVED (Check One)		
				Yearly	Monthly	Weekly
1.						
2.						
3.						
4.						
5.						
6.						

SECTION FOUR Applicant Notification and Signature

The individual signing this application may be asked to prove any or all of your statements. If we ask you to do this, we will tell you how to prove your statements.

We are asking for Social Security number(s) because any person applying for or receiving federal TANF services must give us his or her Social Security number; Social Security numbers are required under federal law (Section 409(a)(4) of the Social Security Act) and federal regulations (45 CFR 264.10). We may use Social Security number(s) to do computer matches with other programs to prove you are receiving these programs (for example, SNAP), to do a computer match to verify other information on the application, or to verify your alien status.

If you disagree with any decisions we make regarding your eligibility to receive TANF services, you may have your certification reviewed by a person at a level above the person who made the first decision.

By signing this, I am swearing, under penalty of perjury, that all of the above statements are true to the best of my knowledge and that I am willing to cooperate with any efforts to verify the information provided.

Signed: _____ Date: _____

Relationship to Applicant: _____

If the applicant lives with his or her parents, a parent or other adult relative caretaker must sign this form for the application to be complete. The Commissioner of the Department of Social Services or his or her designee must sign for children in foster care.



Orleans Youth Employment Program

Initial Assessment

Applicant Name: _____

Race ☐ White ☐ Black or African American ☐ Hispanic or Latino
☐ Alaskan/American Indian ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other

Note: Ethnicity question is voluntary. Information will be kept confidential and is intended for use solely in connection with record keeping and affirmative action requirements. You will not be penalized for refusal to answer.

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, explain in full: _____

Males-18 years and older, are you registered for Selective Service? ☐ Yes ☐ No If no, register at sss.gov

EDUCATION:

High School _____ Grade ____ Do you have ☐ IEP ☐ 504 ☐ AIS Vocational program _____

Earned a high school diploma or equivalency diploma? ☐ Yes ☐ No

SKILLS and INTERESTS

List your skills and abilities you have learned in a job, at home, as a chore, or as a hobby.

List your volunteer and/or community service performed: _____

Which type of worksite do you prefer?

Office	Retail	Assembly and Production	Recreation Program
Outdoor Maintenance	Food Service	Day Care Center	Center for Disabled Adults/Youth
Indoor Maintenance	Nursing Home	Hospitality	Other _____

CAREER INTEREST:

Which of the following high demand jobs are you interested in learning more about?

Advanced Manufacturing: ☐ HVAC ☐ Welding ☐ Optics ☐ Machining ☐ Auto Mechanic

Health Care: ☐ Home Health Aide (HHA) ☐ Certified Nursing Aide (CNA) ☐ Licensed Practical Nurse (LPN) ☐ Registered Nurse (RN)

☐ Agriculture ☐ Truck Driving ☐ Starting your own business

If you could have a job right now, what would it be? _____

What job do you want 5 years from now? _____ Why? _____

TRANSPORTATION: How will you get to a job or appointment? ☐ Bicycle ☐ Parents ☐ Own Car ☐ Public Transportation ☐ Walk

Do you have a driver's license? ☐ Yes ☐ No If No, do you have a Learner's Permit? ☐ Yes ☐ No

WORK HISTORY: (☐ See Attached Resume)

Job Title _____ Employer _____

Address _____ Wage \$ _____

City _____ State _____ Country, if not US _____

Start Date ____/____/____ End Date ____/____/____ Reason for leaving _____

Job Duties _____



County of Orleans
Job Development Agency
14016 Route 31 West
Albion, NY 14411
585-589-2772
585-589-2795 – Fax

YOUTH EMPLOYMENT PROGRAM

Agency Release of Information Form

I / we hereby authorize the release of information to or by the Orleans County Job Development Agency with the agencies listed below in order to determine eligibility and to provide complete and proper Case Management Services. I / we understand that the release will allow communications at needed intervals. I / we understand that this release will be updated annually and may be revoked by me at any time with written notification. Also, I / we understand that I / we may cross out any agency that I / we do not wish to share information with the Orleans County Job Development Agency.

AGENCIES

- | | |
|---|--|
| ▪ Applicant's School District | ▪ Orleans Niagara BOCES |
| ▪ Orleans County Mental Health | ▪ Orleans County Sheriff's Office & Jail |
| ▪ Orleans County Probation | ▪ Orleans County Youth Bureau |
| ▪ NYS One Stop Operating System Database | ▪ Catholic Charities of Tri-Counties |
| ▪ NYS Department of Labor | ▪ Mobile Mental Health team |
| ▪ NYS Career Zone | ▪ GCASA |
| ▪ Orleans County Dept. of Social Services | ▪ ACCESS/VR |
| ▪ Orleans County Dept. of Health | ▪ Upward Bound |
| ▪ GED/TASC Class | ▪ Orleans County Sheriff's office and Jail |
| ▪ Applicant's Worksite and the Supervisor | ▪ College youth may be attending |
| ▪ Literacy Volunteers of Genesee/Orleans County | ▪ Other _____ |

Applicant's Name PRINTED

Applicant's Name SIGNED

Parent/Guardian Signature (If applicant is UNDER 18 years old)

DATE

PHOTO RELEASE

I / We give permission for my photo to be taken at work experience, field trips, and workshops or in other activities sponsored by the Orleans County Job Development Agency as part of the Youth Employment Program. These photos may be published in the newspaper, posted or used in reports and publications / website of the department or of the GLOW Workforce Investment Board and I may not receive monetary compensation.

Applicant's Name PRINTED

Applicant's Name SIGNED

Parent/Guardian Signature (If applicant is UNDER 18 years old)

DATE



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**YOUTH EMPLOYMENT PROGRAM
Participation Agreement**

I, _____
(PRINT NAME OF PARTICIPANT)

Agree to participate in the total Youth Job Development Employment Program and understand that the purpose of the program is to help me develop the skills I will need to succeed in school and work.

As a participant, I will:

1. Respect myself, my co-workers, supervisors, and Job Development staff.
2. Have perfect attendance for work and/or classroom activities.
3. Arrange for my own transportation to and from classroom activities and my work-place.
4. Wear appropriate clothing to pre-employment, employment and classroom activities.
5. Understand that, prior to starting my work assignment, I will need to complete an application, attend an interview/ eligibility appointment, and attend an orientation.
6. Bring a legible copy of my birth certificate, social security card, and picture ID to my eligibility appointment and proof of income if necessary.
7. Understand that there will be mandatory enrichment classroom activities that I will need to attend and complete before my work assignment can start.
8. Understand that my signature on this document constitutes an agreement between me and the Orleans County Job Development Agency.
9. Understand that I, my employer or my education provider may be contacted during and up to one year from my active enrollment in the Orleans County Youth Employment Program to gather information regarding the terms and conditions of my employment and work status.

Participant Signature: _____

Parent/Guardian Signature: _____

Date: _____

ORLEANS COUNTY JOB DEVELOPMENT AGENCY

MEDICAL HISTORY QUESTIONNAIRE

DIRECTIONS This questionnaire must be completed and signed by a parent or guardian prior to enrollment into the Youth Employment Program of the individual listed below. Failure to return this completed form to the Orleans County Job Development Agency office will delay the start of your child's/dependent's employment assignment. Thank you for your cooperation.

PARTICIPANT'S NAME _____

Date of last physical _____ Primary Care
Physician _____

Is your child/dependent covered by health insurance? Yes _____ No _____

If yes, who is the subscriber , the name of the insurance and the contract#

Has your child/dependent ever been treated for or had symptoms of the following:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Heart Problems	_____	_____	Dizziness/Fainting	_____	_____
Breathing Problems	_____	_____	High Blood Pressure	_____	_____
Tuberculosis	_____	_____	Frequent Headaches	_____	_____
Head/Neck Injuries	_____	_____	Vision Problems	_____	_____
Hernia	_____	_____	Epilepsy	_____	_____
Back Injuries	_____	_____	Skin Disorders	_____	_____
Rheumatic Fever	_____	_____	Nervous System Disorder	_____	_____
Scarlet Fever	_____	_____	Frequent Colds/Sore Throat	_____	_____
Anemia	_____	_____	Hearing Loss	_____	_____
Asthma or Allergies	_____	_____	Alcoholism/Drug Addiction	_____	_____
Diabetes	_____	_____			

Has your child/dependent ever had an operation? YES _____ NO _____

If yes, please explain and supply dates: _____

Has your child/dependent ever suffered a previous injury? YES _____ NO _____

If yes, please describe the nature of injury and list dates: _____



Is your child/dependent taking prescription drugs? _____Yes _____No

If yes, please list medications and any special instructions if the need to be administered during work hours. _____

Are there any known physical, mental or medical problems which would prevent or limit your child/dependent from work in our Youth Employment Program? _____Yes _____No

If yes, please describe and explain what accommodations would be necessary: _____

Do you give your permission to have medical assistance provided either at the worksite or at a hospital, should your child/dependent need medical attention at their worksite? _____Yes _____No

Please provide contact numbers you can be reached at during the workday in the event of an emergency.

Mother/Guardian Name

Father/Guardian Name

Home Phone

Work Phone

Home Phone

Work Phone

Cell Phone

Cell Phone

IF A PARENT/GUARDIAN IS UNABLE TO BE REACHED, CONTACT:

Name & Relationship

Name & Relationship

Home Phone

Work Phone

Home Phone

Work Phone

Cell Phone

Cell Phone

My signature below certifies that all information provided is true and correct to the best of my knowledge. I give my permission for my child/dependent to be treated for illness/injury sustained in connection with their participation as a Youth Employee for the Orleans County Job Development Agency. I also give permission for my child/dependent to be transported by a counselor, worksite supervisor, or a Job Development Agency staff member, or ambulance in the event of an emergency.



Sign here: _____
Parent or Guardian Signature

Date

