Jobs League Employment or Training Information

Office of Workforce and Community Initiatives

If participant receives TANF and/or SNAP benefits and has taken part in work or training in the past 30 days:

- Fill out this form to show participant's work and/or training activities during the past 30 days. Complete as much of this form as you can.
- Attach copies of any papers that confirm participant's activities (such as pay-stubs or school schedule).
- Send this form to the SkillUP inbox at SkillUP.Missouri@dss.mo.gov

YOUR INFORMATION

NAME	PHONE NUMBER	DCN *(Required)*	LAST 4 DIGITS OF SSN

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

WORK ACTIVITY #1

NAME	PHONE NUMBER	START DATE	END DATE

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

CURRENT POSITION	AMOUNT EARNED PER PAY PERIOD BEFORE ANY DEDUCTIONS (I.E. TAXES)

PAY PERIOD (CHOOSE ONE)

☐ Monthly ☐ Twice a month ☐ Every 2 Weeks ☐ Weekly ☐ Other

TYPE OF WORK IF APPLICABLE (CHOOSE ONE)

☐ On-the-Job Training ☐ Work Study ☐ Americorps/Visa Stipend ☐ Tips or Bonus
☐ In Kind ☐ Self-Employment ☐ Commission

COMPLETE THE SECTION BELOW FOR EACH PAYMENT YOU HAVE RECEIVED IN THE LAST 30 DAYS

DATE CHECK RECEIVED	RATE OF PAY DO NOT INCLUDED TIPS OR SICK/VACATION PAY	TOTAL HOURS WORKED	EARNINGS BEFORE DEDUCTIONS	TIPS	SICK OR VACATION PAY	OVERTIME AMOUNT INCLUDED IN RATE OF PAY

WORK ACTIVITY #2

NAME	PHONE NUMBER	START DATE	END DATE

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

CURRENT POSITION	AMOUNT EARNED PER PAY PERIOD BEFORE ANY DEDUCTIONS (I.E. TAXES)

PAY PERIOD (CHOOSE ONE)

☐ Monthly ☐ Twice a month ☐ Every 2 Weeks ☐ Weekly ☐ Other

TYPE OF WORK IF APPLICABLE (CHOOSE ONE)

☐ On-the-Job Training ☐ Work Study ☐ Americorps/Visa Stipend ☐ Tips or Bonus
☐ In Kind ☐ Self-Employment ☐ Commission

COMPLETE THE SECTION BELOW FOR EACH PAYMENT YOU HAVE RECEIVED IN THE LAST 30 DAYS

DATE CHECK RECEIVED	RATE OF PAY DO NOT INCLUDED TIPS OR SICK/VACATION PAY	TOTAL HOURS WORKED	EARNINGS BEFORE DEDUCTIONS	TIPS	SICK OR VACATION PAY	OVERTIME AMOUNT INCLUDED IN RATE OF PAY

NAME (LAST, FIRST, MI)	**Last 4 SSN and DCN** *(Required)*

TRAINING AND/OR WORKSHOP #1

TRAINING PROVIDER NAME/DWD WORKSHOP NAME *(Required)*	NO. HOURS IN TRAINING PER MONTH	DATES TRAINING STARTS/ENDS START _____ END _____

ARE YOU RECEIVING ANY EARNINGS FROM TRAINING? ☐ YES ☐ NO • IF YES, LIST AMOUNT $ _____	IF TRAINING PROVIDED BY A COLLEGE, LIST NAME AND ADDRESS OF COLLEGE
FUNDING SOURCE *(Mark appropriate boxes)* SkillUP ____ WIOA ____ Financial Aid ____ Self-Pay ____	

TRAINING AND/OR WORKSHOP #2

TRAINING PROVIDER NAME/DWD WORKSHOP NAME *(Required)*	NO. HOURS IN TRAINING PER MONTH	DATES TRAINING STARTS/ENDS START _____ END _____

ARE YOU RECEIVING ANY EARNINGS FROM TRAINING? ☐ YES ☐ NO • IF YES, LIST AMOUNT $ _____	IF TRAINING PROVIDED BY A COLLEGE, LIST NAME AND ADDRESS OF COLLEGE

EXEMPTION

I AM NOT AVAILABLE TO WORK OR TRAIN BECAUSE

RECEIVING UNEMPLOYMENT INSURANCE BENEFITS: ☐ YES ☐ NO

OTHER SERVICES

LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
		TOTAL HOURS

You must initial on each of these statements indicating that everything stated is true.

_____ • I understand that it is against the law to obtain or attempt to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

_____ • I authorize the Director of Family Support division or his/her appointee to investigate and verify these circumstances and statements.

_____ • I understand if I disagree with the decision concerning our eligibility, I may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

_____ • I understand that I must report any changes in circumstances within ten days of when they happen.

_____ • I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.

SIGNATURE OF APPLICANT	DATE

FOR INTERNAL USE ONLY

PROVIDER AGENCY AND CONTACT NUMBER	CITY
STAFF NAME	STAFF EMAIL