



# 2021 Livingston Youth Employment Program (LYEP) Application

Livingston County Office of Workforce Development

## ALL APPLICANTS

- Must be age 14 by 7/6/21
- Participate in an **unpaid** 3 day work readiness assessment process

### LYEP 101

- This is an introduction to work for 14-20 year olds
- Those assessed to need additional development are assigned to work on a community crew
- Earn \$12.50 /hr and work for 2 weeks
- Worksite location in Mount Morris

### LYEP 201

- Those assessed ready to work are assigned to an individual worksite
  - Earn \$12.50 /hr & must be available to work all 5 weeks
- Returning participants may be selected for a leadership opportunity coinciding with the readiness week. To qualify return application by April 23<sup>rd</sup>.*



### What do we mean by eligible?

- Applicants must be Livingston 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?

- **April 23<sup>rd</sup> – to receive priority interviewing**  
(Interviews will be done remotely via Zoom)



### Where do I send my application?

Livingston County Office of Workforce Development  
6 Court Street, Room 105  
Geneseo, NY 14454  
or Fax to 585-243-7598



### Who do I contact if I have more questions?

Kate Hilfiker @ 243-7047 or [chilfiker@co.livingston.ny.us](mailto:chilfiker@co.livingston.ny.us)



### What happens next?

- Early applicants will get a postcard confirming receipt of application
- Applications received before April 23<sup>rd</sup> will receive priority interview scheduling

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

**Submitting a completed application does not guarantee selection into the program.**

**Livingston County Office of Workforce Development  
Livingston Youth Employment Program (LYEP)**

**List of Documents Required at Eligibility Interview**

Any applicant under 18 years old must have a parent/guardian or designated adult attend the interview

**Income Documents**

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**

You will need proof of all family members income.

- Employment – most recent pay stub with year to date total
- Social security check, award letter, or bank statement showing deposit
- Retirement income statement, check, or bank statement
- Unemployment Insurance – determination letter or payment history print out
- 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
- Statement of Self-Employment income showing income and expenses

**AND**

**Identification and citizenship documents –ORIGINAL Documents required.** We will copy on site.

<p align="center"><b><u>Prove Your Age</u></b></p> <p>○ Birth Certificate <u>OR</u>      ○ Passport <u>OR</u></p> <div style="display: flex; justify-content: space-around;">   </div> <p>○ Driver License/Learner Permit <u>OR</u></p> <div style="display: flex; justify-content: space-around;">   </div> <p>○ Work Permit <u>OR</u></p> 	<p align="center"><b><u>Prove Citizenship</u></b></p> <p>○ Social Security Card</p> <div style="text-align: center;">  <p><b>Requires Signature</b></p> <p><b>AND</b></p> <p>○ Photo ID Driver License, <u>current</u> school ID, Sheriff ID, Safe Kids Card</p>  </div> <p><b>Selective Service</b> required for all males over 18</p> <p align="center"><a href="http://www.sss.gov">www.sss.gov</a></p>	<p>○ <b>Work Permit</b> (if under 18) and please note: a new permit will be needed if turning 16</p> <div style="text-align: center;">  </div> <p>○ <b>Report Card</b> most recent</p> <div style="text-align: center;">  </div>
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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.**



# Livingston Youth Employment Program Initial Assessment

Applicant Name: \_\_\_\_\_

- Ethnicity/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.qov](http://sss.qov)

**EDUCATION** Earned a high school diploma or equivalency diploma?     Yes     No  
High School \_\_\_\_\_ Grade \_\_\_\_ Do you have     IEP     504     AIS    BOCES Vocation program \_\_\_\_\_

**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 \_\_\_\_\_

**HOUSEHOLD** – list all family members living with the applicant. If the applicant is in **foster care**, mark  YES and skip this section.

2. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Earnings: \$ \_\_\_\_\_  
3. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Earnings: \$ \_\_\_\_\_  
4. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Earnings: \$ \_\_\_\_\_  
5. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Earnings: \$ \_\_\_\_\_  
6. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Earnings: \$ \_\_\_\_\_  
7. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Earnings: \$ \_\_\_\_\_

\* If needed, additional family members can be listed on another page.

**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 \_\_\_\_\_



**LIVINGSTON COUNTY  
OFFICE OF WORKFORCE DEVELOPMENT**

Livingston County Government Center  
6 Court Street, Room 105  
Geneseo, NY 14454-1043  
Phone: (585) 243-7047 Fax: (585) 243-7598

**LYEP and YEAR ROUND YOUTH SERVICES PROGRAM  
Agency Release of Information Form**

I/we hereby authorize the release of information to or by the Livingston County Office of Workforce Development 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 communication 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 the Office of Workforce Development to share information with.

\_\_\_\_\_  
Youth's Name (Please Print)

\_\_\_\_\_  
Youth's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (If youth is under 18)

\_\_\_\_\_  
Date

**AGENCIES**

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>• Youth's School District</li><li>• Livingston County Mental Health/SPOA</li><li>• Livingston County Probation</li><li>• Livingston County Youth Advocacy</li><li>• NYS Department of Labor</li><li>• NYS CareerZone</li><li>• Livingston County Dept of Social Services</li><li>• Livingston County Dept of Health</li><li>• Council on Alcohol &amp; Substance Abuse Liv. Co.</li><li>• Literacy West/CORE Learning Center</li><li>• Hillside Family of Agencies</li></ul> | <ul style="list-style-type: none"><li>• Genesee Valley Educational Partnership</li><li>• Mobile Mental Health Team</li><li>• Livingston County Sheriff's Office &amp; Jail</li><li>• Livingston County Youth Bureau</li><li>• Catholic Charities of Livingston County</li><li>• Youth's Worksite Supervisor</li><li>• NYS One Stop Operating System Database</li><li>• Noyes Mental Health</li><li>• ACCES VR</li><li>• _____</li></ul> |
|--|---|

**Photo Release**

I give permission for my photo to be taken at work experience, field trips, workshops or in other activities sponsored by the Livingston County Office of Workforce Development as part of the Summer Youth Employment Program or Year Round Youth Program. These photos may be published in the newspaper, posted or used in reports and publications of the department or of the GLOW Workforce Investment Board.

\_\_\_\_\_  
Youth's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (If youth is under 18)

\_\_\_\_\_  
Date

**Livingston County Office of Workforce Development**  
**Health Information and Emergency Release Form**

NAME: \_\_\_\_\_

The above named participant:

is NOT currently covered by health insurance.

is covered by MEDICAID. # \_\_\_\_\_

is currently covered under \_\_\_\_\_ (Health Ins.)

Policy #: \_\_\_\_\_

**Health Information**

Check the boxes that apply to you.

Are you currently under the care of a physician or other health professional?

Are you currently taking any prescribed medication? If so, what?

Have you been advised to have any surgical procedure or medical treatment?

Have you been hospitalized for a medical or mental health reason within the past 2 years?

Have you received counseling or treatment for drug or alcohol use within the past two years?

Do you have a physical, mental or learning disability?

Do you wear a medical device or orthopedic braces?

Are you allergic to any drugs, medicines, or foods?

Do you have allergic reactions to insect bites or exposure to plants?

FEMALES: Are you Pregnant? If so, provide due date.

Are you able to lift 40 pounds?

Have you had a tetanus shot in the last 10 years?

Anemia or Sickle Cell Disease

Deafness or difficulty in hearing

Blindness or poor eye sight

Epilepsy, seizure, or convulsions

Serious dental problems

Kidney or urination problem

High blood pressure

Speech defect (e.g. stuttering)

Depression or Anxiety

Tuberculosis

Mental illness

Digestive problems

Diabetes

Other health problems

NAME: \_\_\_\_\_

I give permission for my child to be treated for illness/injury sustained in connection with their participation in the Year Round or Summer Youth Employment Program with Livingston County Office of Workforce Development. I also give permission for my child to be transported by a counselor, worksite supervisor, Workforce Development staff member, or ambulance in the event of an emergency.

**In the event an illness or emergency should occur, contact:**

\_\_\_\_\_  
Mother/Guardian Name

\_\_\_\_\_  
Father/Guardian Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone (if different)

\_\_\_\_\_  
Cell Phone (if different)

**If a parent/guardian is unable to be reached, contact:**

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone (if different)

\_\_\_\_\_  
Cell Phone (if different)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_