



# WORKFORCE INVESTMENT AGENCY

Building 1353 | Mednilla Ave. | Capitol Hill | Caller Box 10007 | Saipan, MP 96950  
Tel: (670) 488-1720 | Fax: (670) 664-1710 | Email: cnmiwioa@dol.gov.mp



## 2024 CAREER EXPLORATION SUMMER INTERNSHIP

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

Date: \_\_\_\_\_

Grade Level in SY 2024-2025:  11th  12th

Infinite Campus (IC) Student #: \_\_\_\_\_

### GENERAL ELIGIBILITY REQUIREMENTS

- Completed WIOA Application Form**
- Completed WIOA Youth Objective Assessment Form**
- Completed WIOA Youth Individual Service Strategy (ISS) Form**
- Completed Equal Opportunity Notice Form**
- Proof of Age**  
*(Driver's License, Baptismal Record, Birth Certificate, DD-214, Federal, State or Local Identification Card, U.S./Foreign Passport, Public Assistance Records, School ID Card, Work Permit, Selective Service Registration, Signed Letter from a parent or guardian, Medical Records, Self-Attestation)*
- Social Security Card**  
*(Social Security Card, W-2 Form, Social Security Administration Award Letter, DD-214, Employment Records showing number, Public Assistance Records showing number)*
- Proof of Citizenship**  
*(Alien Registration Card attached with USCIS Form I-151, I-551, I-94, I-668A, I-797, I-179, Baptismal Certificate with Place of Birth, Birth Certificate, DD-214, Foreign Passport stamped Eligible to Work, Naturalization Certification, Voter Registration Card, U.S Passport, I-9/I-94)*
- 6-Month Period of Household Income (Submit ALL that apply)**  
*(Alimony Agreement, Award Letter from Veteran's Administration, Business Financial Records, Compensation Award Letter, Court Award Letter (Child Support), Employer Statement/Contract, Housing Authority Verification, Pay Stubs, Pension/Annuity Statement, Public Assistance Records, Social Security Administration Benefits, Self-Attestation)*
- Selective Service Registration \*For MALES born on or after 01/01/1960\***  
*(Contact with Selective Service (847) 688-6888, DD-214, Selective Service Acknowledgement/Verification, Selective Service Card, Selective Service Status Information Letter attached with Stamped Post Office Receipt)*
- Certification of Disability**  
*(School 504 Records provided by Student, Assessment Test Results, School Individualized Education Program (IEP) record, Self Attestation)*
- Low-Income (Submit ALL that apply)**  
*(NAP Eligibility Verification, NAP Disposition Form, Medicaid Card, SSI/SSDI Receipt of Benefits Verification, SSI/SSDI Eligibility Verification, Public Assistance Records/Printout)*
- School Status Information**  
*(Applicable Records from Education Institution, Self Attestation)*
- Most Current Math and Reading Results**  
*(Current STAR Math and Reading Results, Current SAT 10 Score)*

**If you are unable to provide any of the documents listed, you must fill out a WIOA Applicant Statement as a substitute. This statement will stand in place of any of the missing documents. Any missing documents may be required at a later time.**



**2024 CAREER EXPLORATION SUMMER INTERNSHIP**

**APPLICANT INFORMATION**

**FULL LEGAL NAME:** *(Last Name, First Name, M.I.)*

**SOCIAL SECURITY NUMBER:**



**RESIDENTIAL ADDRESS:** *(Street Name & Village)*

**MAILING ADDRESS:**



**CITY:**

**STATE:**

**ZIP CODE:**

**COUNTRY:**

Saipan  Tinian  Rota

Northern Mariana Islands

United States

**PRIMARY PHONE NUMBER:**

**ALTERNATIVE PHONE NUMBER:**

**EMAIL ADDRESS:**




**EMERGENCY CONTACT:**

**ALTERNATIVE CONTACT:**

Name:

Name:

Contact Number(s):

Contact Number(s):

Relationship:

Relationship:

**DEMOGRAPHIC INFORMATION**

**DATE OF BIRTH:** *(mm/dd/yyyy)*

**AGE:**

**GENDER:**

Male  Female  I do not wish to answer

**CITIZENSHIP:**

Citizen of U.S or U.S Territory  Citizen of Freely Associated States I-9/I-94  Alien/Refugee admitted to U.S  
 U.S Permanent Resident  Other: *Please Specify:* \_\_\_\_\_

**ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES?**  Yes  No

**HAVE YOU REGISTERED FOR SELECTIVE SERVICE?** *(For MALES born on or after 01/01/1960)*  Yes  No  Not applicable

**SELECTIVE SERVICE REGISTRATION NUMBER:**

**SELECTIVE SERVICE REGISTRATION DATE:**



**ETHNICITY:** *Please select ALL that apply*

African American/Black  American Indian/Alaskan Native  White  
 Asian:  Bangladesh  Bhutanese  Cambodian  Chinese  Filipino  Indian  Japanese  Korean  Malaysian  
 Nepalese  Pakistani  Sikkimese  Sri Lankan  Thai  Vietnamese  
 Hawaiian/Other Pacific Islander:  Carolinian  Chamorro  Chuukese  Guamanian  Kosraean  Marshallese  Micronesian  
 Palauan  Pohnpeian  Yapese

**EDUCATION INFORMATION**

I do not have a High School Diploma/Equivalency. Last grade completed was \_\_\_\_\_ grade.  High School Diploma/Equivalent  
 Certificate of Attendance/Completion (Disabled Individuals)  1 year at College or Technical or Vocational School  
 2 years at College or Technical or Vocational School

**ARE YOU CURRENTLY ATTENDING SCHOOL?**  Yes, High School, Junior High, or Elementary School  Yes, College, Technical or Vocational School  No, Not attending any School

**ARE YOU BASIC SKILLS DEFICIENT?** *(Reading/Math Level below 8th grade)*  Yes, Reading/Math is at 8th grade or below  No, Reading and Math is at grade level or above

**DISABILITY INFORMATION**

**DO YOU CONSIDER YOURSELF TO HAVE A DISABILITY?**  Yes  No  I do not wish to disclose

**IF YES, CATEGORY OF DISABILITY:**

Physical/Chronic Health Condition  Physical/Mobility Impairment  Mental/Psychiatric Disability  Vision-related Disability  
 Hearing-related Disability  Learning Disability  Intellectual Disability  I do not wish to disclose

**DO YOU HAVE AN IEP WITH YOUR SCHOOL?**  Yes  No

**HAVE YOU RECEIVED SERVICES FROM VOCATIONAL REHABILITATION?**  Yes  No  I do not wish to disclose

## SPOUSE OR CAREGIVER OF A MILITARY MEMBER INFORMATION

ARE YOU THE SPOUSE OF A MEMBER OF THE ARMED FORCES WHO IS ON ACTIVE DUTY?  Yes  No

ARE YOU A SPOUSE OR FAMILY CAREGIVER TO A MEMBER OF THE ARMED FORCES WHO IS WOUNDED, ILL, INJURED AND RECEIVING TREATMENT IN A MILITARY FACILITY OR WARRIOR TRANSITION UNIT?  Yes  No

ARE YOU THE SPOUSE OF SOMEONE IN THE ACTIVE DUTY MILITARY SERVICE, NATIONAL GUARD OR RESERVES WHO IS CURRENTLY ACTIVATED?  Yes  No

ARE YOU THE SPOUSE OF A VETERAN WHO HAS A PERMANENT, TOTAL SERVICE CONNECTED DISABILITY OR HAD THE DISABILITY AT THE TIME OF DEATH, OR DIED WHILE THE DISABILITY WAS IN EXISTENCE?  Yes  No

OR  
A SPOUSE OF A SERVICE MEMBER ON ACTIVE DUTY WHO DIED OR HAS BEEN MISSING IN ACTION (MIA), CAPTURED IN THE LINE OF DUTY OR FORCIBLY DETAINED FOR A TOTAL OF MORE THAN 90 DAYS?  Yes  No

## EMPLOYMENT INFORMATION

### CURRENT EMPLOYMENT STATUS:

- Employed:  Full-Time  Part-Time  
 Employed, but received notice of termination of employment or military separation  
 Not employed  
 Never worked

### TYPE OF BUSINESS WORKED IN:

- Private business  Higher education  
 Local government  State government  
 Federal government  Education (K-12)  
 Non-profit organization  Other:

IF YOU ARE CURRENTLY UNEMPLOYED, WHEN WAS YOUR LAST EMPLOYMENT? (mm/dd/yyyy) \_\_\_\_\_

ARE YOU UNEMPLOYED DUE TO LAYOFF OR TERMINATION?  Yes  No  Not Applicable

DO YOU HAVE A RESUME?  Yes  No IF YES, WAS ONE PROVIDED?  Yes  No

DO YOU REQUIRE ADDITIONAL ASSISTANCE TO SECURE/HOLD EMPLOYMENT?  Yes  No

### EMPLOYMENT HISTORY:

Company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job title: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start date (mm/dd/yyyy): \_\_\_\_\_ End date (mm/dd/yyyy): \_\_\_\_\_

Reason for leaving:  Laid off  Quit  Terminated  Other employment  Temporary/Contract ended  Other

Explain reason: \_\_\_\_\_

Company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job title: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start date (mm/dd/yyyy): \_\_\_\_\_ End date (mm/dd/yyyy): \_\_\_\_\_

Reason for leaving:  Laid off  Quit  Terminated  Other employment  Temporary/Contract ended  Other

Explain reason: \_\_\_\_\_

Company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job title: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Start date (mm/dd/yyyy): \_\_\_\_\_ End date (mm/dd/yyyy): \_\_\_\_\_

Reason for leaving:  Laid off  Quit  Terminated  Other employment  Temporary/Contract ended  Other

Explain reason: \_\_\_\_\_

## DISPLACED HOMEMAKER/DISLOCATED WORKER INFORMATION

WITHIN THE LAST 12 MONTHS, HAVE YOU RECEIVED A NOTICE OF TERMINATION OR LAYOFF FROM YOUR JOB OR RECEIVED DOCUMENTATION THAT YOU ARE SEPARATING FROM MILITARY SERVICE?  Yes  No

IF YES, LAYOFF/SEPARATION DATE: \_\_\_\_\_ DISLOCATION EMPLOYER: \_\_\_\_\_

DISLOCATION EMPLOYER ADDRESS: \_\_\_\_\_ DISLOCATION HOURLY RATE: \_\_\_\_\_

WERE YOU DEPENDENT ON THE INCOME OF A FAMILY MEMBER, SPOUSE, OR SIGNIFICANT OTHER OR PROVIDING UNPAID SERVICES, BUT NO LONGER SUPPORTED BY THAT INCOME DUE TO: *Please select ALL that apply*

Divorce/Separation  Death  Incarceration  Relocation  Other: \_\_\_\_\_  Not applicable

WERE YOU SELF-EMPLOYED AS A FARMER, RANCHER, FISHERMAN, ETC?  Yes  No

## PUBLIC ASSISTANCE AND PARTNER SERVICES INFORMATION

**WITHIN THE LAST SIX MONTHS, DID YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE ASSISTANCE FROM ANY OF THE FOLLOWING:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Childcare Assistance (DCCA-CCDF)        | <input type="checkbox"/> Housing Assistance                          | <input type="checkbox"/> Karidat              |
| <input type="checkbox"/> DCCA-Nutrition Assistance Program (NAP) | <input type="checkbox"/> Supplemental Security Income (SSI)          | <input type="checkbox"/> WIOA Title I Program |
| <input type="checkbox"/> Medicaid Program                        | <input type="checkbox"/> Social Security Disability Insurance (SSDI) |   |

**ARE YOU RECEIVING SERVICES FROM ANY OF THE FOLLOWING PARTNER PROGRAM SERVICES?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adult Basic Education                 | <input type="checkbox"/> Substance Abuse, Addiction, and Rehabilitation | <input type="checkbox"/> DOL-Employment Services          |
| <input type="checkbox"/> Office of Vocational Rehabilitation   | <input type="checkbox"/> CGC-Transitional Living Center                 | <input type="checkbox"/> Veterans Administration Benefits |
| <input type="checkbox"/> Northern Marianas Technical Institute | <input type="checkbox"/> Office of Adult Probation                      |   |
| <input type="checkbox"/> CNMI Drug Court                       | <input type="checkbox"/> DCCA-Division of Youth Services                |   |

## INDIVIDUAL BARRIERS INFORMATION

**ARE YOU A PREGNANT OR PARENTING YOUTH?**  Yes  No

**ARE YOU HOMELESS?**  Yes  No

**ARE YOU A RUNAWAY YOUTH?**  Yes  No

**HAVE YOU BEEN CONVICTED OF A CRIME?**  Yes  No

**IS YOUR NATIVE LANGUAGE OTHER THAN ENGLISH?**  Yes  No

**ARE YOU CURRENTLY IN FOSTER CARE?**  Yes  No

## ADDITIONAL INFORMATION

**HOW DID YOU HEAR ABOUT US?**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Website            | <input type="checkbox"/> Job Fair       | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Business Colleague | <input type="checkbox"/> Job Center     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Family/Friends     | <input type="checkbox"/> Advertisements |                                       |

**WHAT ARE YOUR JOB PREFERENCES?** (i.e. Cashier, Waiter, Office Clerk, etc.)

1.

2.

3.

**RELEASE OF INFORMATION CONSENT/CERTIFICATION AND ACKNOWLEDGEMENT**

**APPLICANT NAME:**

**RELEASE OF INFORMATION**

**INITIAL**

I agree to allow the CNMI Department of Labor-Workforce Investment Agency Division to share the above information and other relevant information to other agencies for the purpose of assisting me in obtaining my educational, training and/or employment goal as well as obtain support services that may be available.

\_\_\_\_\_

**RELEASE OF INFORMATION FOR EDUCATION INSTITUTIONS**

**INITIAL**

I authorize the release of my current and past educational records from high schools, colleges, universities, and training schools to the CNMI Department of Labor-Workforce Investment Agency Division. Such records include my current/past enrolment(s), transcripts, attendance records, graduation/completion information and diploma/certificate(s)/credential(s) attained. I understand that under the Family Educational Rights and Privacy Act of 1974 (FERPA), which is a Federal Law that protects the privacy of student education records that the staff of DOL-WIA Division must have my written consent to obtain my educational records. I certify that this authorization of release form may be sent as fax, email or a photo copy presented in person with appropriate identification from the above agency's staff to record holder.

\_\_\_\_\_

**RELEASE OF INFORMATION FOR EMPLOYMENT**

**INITIAL**

I authorize the release of my current and past employment information to the CNMI Department of Labor-Workforce Investment Agency Division without liability, any information in their possession relevant to my current or past employment. Such records include information related to my job title, start/end date, hourly wages, hours worked per week, and performance.

\_\_\_\_\_

**CERTIFICATION AND ACKNOWLEDGEMENT**

**INITIAL**

I certify that the information provided is true, complete, and correct to the best of my knowledge. I understand that my willful misstatement of the facts may cause my forfeiture of rights in the WIOA Program and may result in criminal actions. I give my permission for outside sources to be contacted and for them to disclose any information necessary to verify my eligibility for WIOA Title I Programs and Services. I further understand and agree that my social security number and other information on this application will be provided to other government agencies if required by law or necessary for participation.

\_\_\_\_\_

**PLEASE READ CAREFULLY BEFORE SIGNING**

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent of Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

DOL-WIA Staff Signature \_\_\_\_\_

Date: \_\_\_\_\_

## FAMILY SIZE AND HOUSEHOLD INCOME AND ADDRESS VERIFICATION

I, \_\_\_\_\_ currently reside at \_\_\_\_\_  
*Applicant Name* *Street name and Village*

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ with the following household members:  
*City* *State* *Zip Code*

<u>NAME OF HOUSEHOLD MEMBER</u>	<u>RELATIONSHIP TO APPLICANT</u>	<u>SOURCE OF INCOME IN THE LAST 6 MONTHS</u>
1. _____	<b>Self</b>	<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
2. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
3. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
4. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None
5. _____		<input type="checkbox"/> Wages <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> SSI/SSDI Benefits <input type="checkbox"/> Other <input type="checkbox"/> VA Benefits <input type="checkbox"/> Self-Employment <input type="checkbox"/> None

**NOTE: FOR HOUSEHOLDS OF MORE THAN 5, PLEASE USE THE BACK SIDE OF THIS PAGE OR A SEPARATE SHEET FOR ADDITIONAL HOUSEHOLD MEMBERS.**

**PLEASE READ CAREFULLY BEFORE SIGNING**

I certify that the information provided is true, complete, and correct to the best of my knowledge. I understand that falsification of data is a crime and is subject for immediate termination from CNMI DOL-WIA Division Title I Programs and Services and any monies paid to or on behalf of the participant will require repayment.

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

Signature of Parent of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

Received by: \_\_\_\_\_  
*DOL-WIA Staff Print and Sign*

Household Size: \_\_\_\_\_ 6 Month Income: \_\_\_\_\_

Certified by: \_\_\_\_\_  
*DOL-WIA Staff Print, Sign and Date*

**STAFF NOTES**

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Stamp received date



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## WIOA YOUTH OBJECTIVE ASSESSMENT FORM

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

Infinite Campus (IC) Student #: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Village: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

### PROGRAM EXPECTATIONS

Are you seeking to participate in the Career Exploration Summer Internship?  Yes  No

What services are you seeking? *i.e, Employment Training, Job Placement Assistance, Labor Market Information, etc.*

Career Exploration Summer Internship

Other (Please Specify): \_\_\_\_\_

### EMPLOYMENT EXPECTATIONS

*What are the top three (3) careers you would like to explore?*

Desired Job 1: \_\_\_\_\_

Desired Job 2: \_\_\_\_\_

Desired Job 3: \_\_\_\_\_

Employment Type: *What type of employment do you wish to have?*

Regular  Temporary  Seasonal  Contract  Volunteer  Internship  On the Job Training

Full or Part Time:  Full-Time  Part-Time  Both

Do you need assistance with Career Planning?  Yes  No

Are you seeking Training Services?  Yes  No

If YES, what are your training preferences?

Career Exploration Summer Internship

Other (Please Specify): \_\_\_\_\_

Do you plan to attend College after High School?  Yes  No

If YES, what are your Post-Secondary preferences?

College  Military (Please Specify): \_\_\_\_\_

Trades/Vocational School  Other (Please Specify): \_\_\_\_\_

Other Assistance Expected: *i.e, Transportation Assistance, Childcare Assistance, etc.*

### EDUCATION HISTORY

What is the highest grade you have completed? \_\_\_\_\_

Are you currently enrolled in school?

Yes, High School  Yes, Alternative High School  Yes, College or Technical/Vocational Institute  No

If YES, specify school:  KHS  MHS  SSHS  Da'ok Academy  Other, Private School

## BASIC SKILLS/EDUCATION FACTORS

Are you a High School Dropout?  Yes  No

Are you Basic Skills Deficient? *Reading or Math scores at or below 8th grade level*

Reading below 8th grade  Math below 8th grade  Language below 8th grade  Low Literacy

Non-Reader  No

Do you lack Computer Skills?  Yes  No

What is the Primary Language spoken at home: \_\_\_\_\_

Do you require interpretation services? *i.e, Translator*  Yes  No

Are you limited in English?  Yes  No

## WORK READINESS

What are some of your Occupational Transferrable Skills? *i.e, Customer Service, Monetary Management, Computer Skills, Problem Solving, Communication, etc.*

Do you have any children below the age of 18?  Yes  No

If YES, how many? \_\_\_\_\_

Dependent Care Needs:  Child Care  Special Needs Child  Adult Care  None

Do you own a Driver's License?  Yes, I have a Valid Driver's License  No, I do not own a Driver's License

Suspended  Restrictions  DUI

Do you have transportation?  Owns Automobile  Automobile Needs Repair  Lacks Auto Insurance

Cannot Afford Gas  Automobile Impounded  Automobile Repossessed  Dependable Transportation

Access to Public Transportation  Relies on Public Transportation  None at this time

Contacts:  Telephone in Home  Access to Telephone (Neighbor/Other)  Adequate Contact Person(s)

Do you have appropriate Work Attire?  Uniforms  Interviewing Clothes  Needs Work Tools/Equipment

Do you have any Emergency Food/Nutritional Needs:  Yes  No

## WORKPLACE BEHAVIOR

Do you have any Motivational Factors affecting Employment?  Negative Work Attitude  Punctuality Issues

Attendance Problems  Co-Worker Relations Issues  None at this time

Career Decision Making: *Clearly defined goals/plans*  Yes  No

How are your interviewing skills?  Difficulty Making Positive First Impression  Negative Attitude

Proper Interview Attire  Need to Improve Communication Skills  Research Labor Market Information (LMI)

Questions for Interviewer  Preview List of most common Q&A's  Verbally explain work experience and skills

References  None at this time

Do you have a Resume?  I have an acceptable Resume  My Resume needs revision  None at this time

Application Completion:  Lacks Thoroughness  Needs to Address Sensitive Issues (*i.e. Criminal Record*)

Neatness  Difficulty Summarizing Skills/Work History

Do you have any Appearance/Hygiene Issues:  Yes  No

Do you require assistance with Labor Market Information?  Yes  No

## HEALTH AND BEHAVIORAL OBSERVATIONS

Does any of the following health issues apply to you? *Please select ALL that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> I lack Medical Insurance Coverage | <input type="checkbox"/> I cannot afford Medication                         |
| <input type="checkbox"/> I disclosed a Disability          | <input type="checkbox"/> I require reasonable accommodations                |
| <input type="checkbox"/> I need Glasses                    | <input type="checkbox"/> I have limitations in ability to work certain jobs |
| <input type="checkbox"/> I need Dental Work                | <input type="checkbox"/> My health has been cause for Absence from Job      |
| <input type="checkbox"/> I have a Speech Impairment        | <input type="checkbox"/> I am pending Surgery/Medical Leave                 |
| <input type="checkbox"/> None at this time                 |   |

Does any of the following behavioral issues apply to you? *Please select ALL that apply*

- |   |  |
|---|--|
| <input type="checkbox"/> I have Low Self-Esteem     | <input type="checkbox"/> I require Therapy/Treatment |
| <input type="checkbox"/> I have Behavioral Problems | <input type="checkbox"/> I disclosed a Disability    |
| <input type="checkbox"/> I require Medication       | <input type="checkbox"/> None at this time           |

Do you have any substance abuse issues?  I am seeking Referral for Treatment  I failed a Drug Test  None

## LIVING ENVIRONMENT

Are you experiencing any of the following housing/home life issues? *Please select ALL that apply*

- |   |  |
|---|--|
| <input type="checkbox"/> I am Homeless                      | <input type="checkbox"/> I have Substandard Living Conditions        |
| <input type="checkbox"/> I reside in a Shelter              | <input type="checkbox"/> I am at risk of becoming Homeless           |
| <input type="checkbox"/> I am facing possible eviction      | <input type="checkbox"/> I lack a Family Support System              |
| <input type="checkbox"/> I am a Victim of Domestic Violence | <input type="checkbox"/> I am in a High Risk Family/Living Situation |
| <input type="checkbox"/> None at this time                  |  |

## OTHER ASSISTANCE RECEIVED

Are you receiving assistance from any of the following programs? *Please select ALL that apply*

- |   |   |
|---|---|
| <input type="checkbox"/> Adult Education                    | <input type="checkbox"/> Social Security Income (SSI) |
| <input type="checkbox"/> Foster Care                        | <input type="checkbox"/> Vocational Rehabilitation    |
| <input type="checkbox"/> Job Corps                          | <input type="checkbox"/> Veterans Administration      |
| <input type="checkbox"/> Housing                            | <input type="checkbox"/> Vocational Education         |
| <input type="checkbox"/> Medicaid                           | <input type="checkbox"/> Other:                       |
| <input type="checkbox"/> Nutrition Assistance Program (NAP) | <input type="checkbox"/> None                         |

## BARRIERS TO EMPLOYMENT

Do you lack significant Work History?  Yes  No

Do you have a Sporadic or Limited Work History?  Yes  No

Do you have a Restricted Commuting Distance?  Yes  No

Do you have a Restricted Work Schedule?  Yes  No

Are you facing any legal issues?  Yes: \_\_\_\_\_  No

Are you a Pregnant or Parenting Teen?  Yes  No

If YES, are you a Single Parent?  Yes  No

Are you a Displaced Homemaker? (*Dependent on an income but, no longer supported by that income*)  Yes  No

## ACCESS ASSESSMENT

Are any of the following tasks difficult for you to perform independently in daily life? *Please select ALL that apply*

- |   |  |
|---|--|
| <input type="checkbox"/> I choose not to answer | <input type="checkbox"/> Using Hands               |
| <input type="checkbox"/> None                   | <input type="checkbox"/> Getting around            |
| <input type="checkbox"/> Seeing                 | <input type="checkbox"/> Interacting with others   |
| <input type="checkbox"/> Hearing                | <input type="checkbox"/> Learning or thinking      |
| <input type="checkbox"/> Talking                | <input type="checkbox"/> Other ( <i>Specify</i> ): |

**Do you need any of the following assistance for program participation or employment? *Please select ALL that apply***

- |   |  |
|---|--|
| <input type="checkbox"/> I choose not to answer               | <input type="checkbox"/> Personal coaching                                 |
| <input type="checkbox"/> None                                 | <input type="checkbox"/> Scent free environment                            |
| <input type="checkbox"/> Wheelchair accessible facilities     | <input type="checkbox"/> Screen Magnifier                                  |
| <input type="checkbox"/> Assistance with writing              | <input type="checkbox"/> Screen Reader                                     |
| <input type="checkbox"/> Audiotaped materials                 | <input type="checkbox"/> Interpretation ( <i>including sign language</i> ) |
| <input type="checkbox"/> Flexibility ( <i>i.e. in hours</i> ) | <input type="checkbox"/> Considerations for medication                     |
| <input type="checkbox"/> Materials in Braille                 | <input type="checkbox"/> Alternative seating arrangements                  |
| <input type="checkbox"/> Materials in Electronic Format       | <input type="checkbox"/> TTY/Text Display Devices                          |
| <input type="checkbox"/> Materials in Large Print             | <input type="checkbox"/> Videophone  |
| <input type="checkbox"/> Meeting reminders                    | <input type="checkbox"/> Other ( <i>Specify</i> ):                         |
| <input type="checkbox"/> Notetakers for regular meetings      |  |

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Applicant Print & Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian Print & Sign: \_\_\_\_\_ Date: \_\_\_\_\_

DOL-WIA Staff Print & Sign \_\_\_\_\_ Date: \_\_\_\_\_



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## WIOA YOUTH INDIVIDUAL SERVICE STRATEGY (ISS)

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

Infinite Campus (IC) Student #: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Village: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

### GOALS

*(Identify educational, and occupational training short- and long-term goals)*

Type of Goal <i>(Educational or Occupational Training)</i>	Term of Goal <i>(Short-Term or Long-Term)</i>	Description of Goal <i>(Brief explanation of your goal)</i>	Estimated Completion Date <i>(When will you finish)</i>
<b>Example: Educational</b>	<b>Short</b>	<b>Get a High School Diploma</b>	<b>May 15, 2025</b>
1.			
2.			
3.			

### OBJECTIVES

*(Actions to help you achieve your goals)*

Description of Goal <i>(Brief explanation of your goal)</i>	Objective <i>(What can you do to help achieve your goals)</i>
<b>Example: High School Diploma</b>	<b>Maintain grades and attendance to meet high school credit requirements in order to graduate.</b>
1.	
2.	
3.	

**PLEASE READ CAREFULLY BEFORE SIGNING**

I, \_\_\_\_\_ agree to the following:  
(Print Name)

1. To contact my Case Manager monthly or as often as necessary to update my progress on this plan. I understand that my case can be closed if I go ninety (90) days without participating in a service.
2. To let my Case Manager know of any problems which would cause changes to any activities or interfere with completing the plan.
3. To seek, accept and maintain employment that meets my planned goal(s) as stated above.
4. To contact my Case Manager when I receive my high school diploma, gain employment, or enter a post-secondary educational institute.
5. To stay in contact with my Case Manager for up to a year after exiting the program to maintain and support meeting my goals.

Applicant Print & Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian Print & Sign: \_\_\_\_\_ Date: \_\_\_\_\_



## COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

### DEPARTMENT OF LABOR – WORKFORCE INVESTMENT AGENCY

Bldg. 1353 | Mednilla Ave. | Capitol Hill | Caller Box 10007 | Saipan, MP 96950

Tel: (670) 488-1720/2312 | Fax: (670) 664-1710 | Email: [cnmiwioa@dol.gov.mp](mailto:cnmiwioa@dol.gov.mp)



## EQUAL OPPORTUNITY IS THE LAW NOTICE

It is against the law for this recipient of Federal financial assistance to discriminate on the following bases: against any individual in the United States, on the basis of race, color, religion, sex (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity), national origin (including limited English proficiency), age, disability, or political affiliation or belief, or, against any beneficiary of, applicant to, or participant in programs financially assisted under Title I of the Workforce Innovation and Opportunity Act, on the basis of the individual's citizenship status or participation in any WIOA Title I–financially assisted program or activity.

The recipient must not discriminate in any of the following areas: deciding who will be admitted, or have access, to any WIOA Title I–financially assisted program or activity; providing opportunities in, or treating any person with regard to, such a program or activity; or making employment decisions in the administration of, or in connection with, such a program or activity.

Recipients of federal financial assistance must take reasonable steps to ensure that communications with individuals with disabilities are as effective as communications with others. This means that, upon request and at no cost to the individual, recipients are required to provide appropriate auxiliary aids and services to qualified individuals with disabilities.

### WHAT TO DO IF YOU BELIEVE YOU HAVE EXPERIENCED DISCRIMINATION

If you think that you have been subjected to discrimination under a WIOA Title I–financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either: the recipient's Equal Opportunity Officer (or the person whom the recipient has designated for this purpose);

Ms. Leila F. Staffler  
CNMI Department of Labor Equal Opportunity Officer  
Bldg #1356 Mednilla Ave  
Caller Box 10007  
Saipan, MP 96950  
Telephone: (670) 664-3196.

*Or*

Director, Civil Rights Center (CRC),  
U.S. Department of Labor  
200 Constitution Avenue NW, Room N-4123,  
Washington, DC 20210

*or*

electronically as directed on the CRC website at [www.dol.gov/crc](http://www.dol.gov/crc).

If you file your complaint with the recipient, you must wait either until the recipient issues a written Notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (see address above). If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you may file a complaint with CRC before receiving that Notice. However, you must file your CRC complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient). If the recipient does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

CNMI DOL Workforce Investment Agency is an equal opportunity employer/program.  
Auxiliary aides and services are available upon request to individuals with disabilities



## WIOA COMPLIANT & GRIEVANCE PROCEDURE NOTICE

Under WIOA, customer program complaints and grievances are viewed as opportunities to improve services. The primary goal of this complaint process is to address specific customer concerns, resolve the issues in the most expedient manner, learn from the complaint and grievance and implement resolutions throughout the entire system. All WIOA customers, applicants and participants have the right to complain about the quality or type of service they receive at a WIOA service provider or training provider. This includes complaints about the determination of eligibility or appropriateness for training or other WIOA related services and activities.

The State Workforce Development Board (SWDB) is the appropriate agency of contact when the complaint specifically concerns WIOA Title I-B, and WIOA-related regulations or policies administered by the DOL Workforce Investment Agency or its contracted WIOA service providers. In addition to Grievances against an employer for violations of labor standards. It does not cover complaints about WIOA mandated partner programs.

Such complaints should be made via the internal processes of those partner organizations. However, the DOL Workforce Investment Agency can provide information about contacting the appropriate representatives at these organizations.

All Complaints and Grievances must be filed within 180 days of the alleged violation, to be considered by the State Workforce Development Board (SWDB) Grievance Committee. The Complainant and Grievant must file the Complaint or Grievance in writing to the SWDB Grievance Committee by completing the Customer Program Complaint and Grievance Form describing the complaint and any actions taken for resolution.

The completed Customer Complaint Forms must be mailed, emailed, or faxed to:

State Workforce Development Board  
Attention: Grievance Committee  
P.O. Box 10007  
Saipan, MP 96950

For customer assistance call (670) 488-1720; email your inquiry to [cnmiswdb@dol.gov.mp](mailto:cnmiswdb@dol.gov.mp) or  
Fax: (670) 664-1710

All individuals filing Complaints and Grievances shall be free from restraint, coercion, retaliation, and discrimination. Upon receipt of a complaint or grievance the SWDB Grievance Committee shall acknowledge receipt of the complaint/grievance, if possible, by certified mail, return receipt requested. This will be done

within

ten (10) days of receipt of the complaint or Grievance. If sending an acknowledgement via certified mail is not reasonable or possible, it may be sent by e-mail or regular U.S. Mail. This acknowledgement shall be sent to the Complainant/Grievant and the Respondent(s) and shall: 1) Attach a copy of the Complaint/Grievance filed; 2) Outline the steps to be taken to resolve the matter; 3) Advise the Parties to attempt to reach an informal

resolution;

4) Notify all Parties of the right to request a hearing if an informal resolution cannot be met and; 5) Provide a summary of the issues to be decided.



**Workforce Investment Agency**

**NOTICE OF RIGHTS ACKNOWLEDGEMENT FORM**

I acknowledge receipt of copies of the following Notice of Rights on \_\_\_\_\_(date)

- Equal Opportunity is the Law Notice
- WIOA Grievance Procedure Notice

I have read the above marked notices and understand that I have a right to file discrimination or programmatic complaints if I feel that my rights were violated by a WIOA Title I financially assisted program or activity.

This information was provided in the following language/format:

- English                       Chamorro                       Carolinian
- Other Language (Specify) \_\_\_\_\_
- Alternate Format (Specify)\_\_\_\_\_

*\*DOL WIA staff shall check the box (one only) that is appropriate to the individual.*

Participant means an individual who has been determined to be eligible to participate in, and who is receiving any aid, benefit, service, or training under, a program or activity financially assisted in whole or in part under Title I of WIOA. This includes participants in WIOA Adult, Dislocated Worker, and Youth programs, National Dislocated Worker Grant participants, and any other program for which a hard-copy participant file is required. The individual or individuals intended by Congress to receive aid, benefits, services, or training from a recipient.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign

Recipient means an entity that receives financial assistance under Title I of WIOA. "Recipient" includes but is not limited to: State-level agencies that administer, or are financed in whole or in part with, WIOA Title I funds; State Workforce Agencies; State and Local Workforce Development Boards; Local Workforce Development Area grant recipients; One-stop operators; Service providers, including eligible training providers; On-the-Job Training employers; and other National Program recipients.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign

Applicant for employment means a person or persons who make(s) an application for employment with a recipient of federal financial assistance under WIOA Title I.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign

For additional information about DOL Workforce Investment Agency, contact the career center by email at [cnmiwioa@dol.gov.mp](mailto:cnmiwioa@dol.gov.mp) or (670) 488-1720.