



Rhode Island Indian Council, Inc.

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Workforce Innovation and Opportunity Act (WIOA) Enrollment Form

Fill out completely and initial at bottom of every page or form is invalid.

1) SSN: _____ 2) DOB: _____ / _____ / _____ Age: _____

3) Last Name: _____ 4) First Name: _____

5) Address: _____

House/Building #

Street

Unit/Apartment #

City/Town

State

Zip Code

6) Primary Phone # _____ Secondary Phone # _____

7) Family Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Common Law

8) Indian Status

☐ American Indian

Tribal Affiliation: _____

☐ Native Alaskan

Enrolled? ☐ Yes ☐ No – *see your counselor*

☐ Native Hawaiian

If yes, Enrollment #: _____

9) Gender: ☐ Male ☐ Female ☐ Two Spirit ☐ Nonbinary ☐ Prefer not to answer

10) Selective Service Registration Status: *All males ages 18-25 must be registered.*

Copy of Selective Service Card? ☐ Yes

Verification Attached? ☐ Yes

☐ No

☐ No

11) Employment Status

Unemployed last seven (7) days? ☐ Yes ☐ No

If yes, last day worked: _____ / _____ / _____

Underemployed: currently working part-time? ☐ Yes ☐ No

12) Education Status: Highest Degree (check one below)

☐ High School Diploma

☐ GED

☐ College Degree

If none, highest grade completed: _____

Are you a full-time student? ☐ Yes ☐ No

Name of School: _____

Client Initials

Date

Counselor Initials

Date



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Type of Program: ☐ High School ☐ GED ☐ Postsecondary Education / Training ☐ College

Do you have any special licenses or certificates? ☐ Yes ☐ No

If yes, please describe: _____

13) If you have children, do you have childcare available? ☐ Yes ☐ No ☐ N/A (not applicable)

14) Do you have reliable transportation? ☐ Yes ☐ No

15) Veteran Status: Are you a veteran? ☐ Yes ☐ No If yes, date of entry: ____ / ____ / ____

Date of discharge: ____ / ____ / ____ Type of discharge: _____

Do you have a disability? ☐ Yes ☐ No

16) Are you handicapped? ☐ Yes ☐ No If yes, please explain: _____

17) Do you have any substance abuse concerns? ☐ Yes ☐ No

If yes, please explain: _____

18) Are you currently under prescription medication? ☐ Yes ☐ No

If yes, please state medication and reason: _____

19) Are you currently under a doctor's care? ☐ Yes ☐ No

If yes, please explain: _____

20) Are you a Vocational Rehabilitation referral? ☐ Yes ☐ No

If yes, please state contact name: _____

If no, would you like to be referred to a Vocational Rehabilitation program? ☐ Yes ☐ No

21) Criminal History: Have you ever been incarcerated, paroled, or on probation? ☐ Yes ☐ No

If yes, please explain: _____

Client Initials

Date

Counselor Initials

Date



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Are you currently incarcerated? ☐ Yes ☐ No If yes, date of release: _____

Are you currently in any phase of an adjudication process? ☐ Yes ☐ No

22) State of legal residence: _____ How long? _____

23) Do you have a valid driver's license? ☐ Yes ☐ No If yes, state: _____ License # _____

24) Have you ever been, or are you currently, institutionalized? ☐ Yes ☐ No

If yes, please name institution: _____

25) Is any member of your family employed by the WIOA program in any administrative or supervisory capacity? ☐ Yes ☐ No

If yes, state name and position: _____

26) Are you currently economically disadvantaged? ☐ Yes ☐ No

AFDC? ☐ Yes ☐ No If yes, date payments began: _____ / _____ / _____

SNAP? ☐ Yes ☐ No

SSI? ☐ Yes ☐ No

General Assistance? ☐ Yes ☐ No

27) Prior WIOA status: Have you ever participated in WIOA before? ☐ Yes ☐ No

If yes, please complete the following: _____

Sponsoring Organization

City / State

Dates of participation: _____ to _____

28) Have you ever worked a full-time job for two (2) weeks or more? ☐ Yes ☐ No

29) How many weeks in the past 52 weeks were you employed? _____



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30) List all the jobs you have worked during the past 12 months, beginning with the most recent:

Employer	Position	Hrs / Wk	Hrly Wage	Start Date	End Date	Reason for Leaving

Certification Statement

I understand that the information provided in this application is used for program eligibility and that it will not be released without my permission. I am also aware that documentation to support my statements may be required and that refusal to provide such documentation will result in ineligibility for program services.

I certify that the information provided is true to the best of my knowledge. I also certify that I understand providing false or misleading statements will result in immediate termination from program services and may be cause for civil and/or criminal prosecution.

Applicant's Signature

Date

This is to acknowledge that I have received a Notice of Rights to Grievances Procedures.

Applicant's Signature

Date

Counselor Signature

Date

Client Initials

Date

Counselor Initials

Date