SUMMER YOUTH EMPLOYMENT PROGRAM 2021

PROGRAM DATES: July 6th – July 29th 2021 (these are tentative dates)

TENTATIVE PROGRAM SPECIFICS:

- 4 weeks of work, learning, and personal growth
- Youth work within their community; worksites vary throughout Madison County
- Youth will be paid minimum wage ($12.50) for up to 22 hours per week

ELIGIBILITY: How do I know if I am eligible?

You are eligible for the SYEP if you are a Madison County resident, between 14-20 years old, and if EITHER 1 or 2 (below) applies to you:

1. If you (the youth applicant) currently receive benefits under one or more of these programs:
   - Family Assistance
   - Medicaid
   - SNAP (Food Stamps)
   - SSI
   - HEAP

2. A member of a family whose income falls below the amount shown for your family/household size:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Annual Income</th>
<th>Family Size</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$25,760</td>
<td>5</td>
<td>$62,080</td>
</tr>
<tr>
<td>2</td>
<td>$34,840</td>
<td>6</td>
<td>$71,160</td>
</tr>
<tr>
<td>3</td>
<td>$43,920</td>
<td>7</td>
<td>$80,240</td>
</tr>
<tr>
<td>4</td>
<td>$53,000</td>
<td>8</td>
<td>$89,320</td>
</tr>
</tbody>
</table>

If you have any questions or would like an application, please call Jenny Buckley @ 315-363-2400
2021 Summer Youth Employment Program (SYEP)

To the Parent/Guardian of: _______________________________ Date: ______________

Enclosed is the SYEP application that needs to be completed and returned back AS SOON AS POSSIBLE to determine if you are eligible to participate.

The program will (tentatively) run from Tuesday, July 6, 2021 until Thursday, July 29, 2021. Youth will work an approximate 6 hour work day, Monday through Thursday, and be given a 30 minute unpaid lunch break.

**COMPLETED APPLICATIONS WILL HAVE**

- Completed TANF application (signed by parent/guardian on page 2)
- Copy of birth certificate and social security card
- Completed medical form
- Updated shot record
- ORIGINAL working card

**Working Cards:**
Youth who are under 18 years old will need a working card to participate.
- 14-15 year olds – your working card is blue
- 16-17 years enrolled in school – your working card is green
- 16-17 not enrolled in school – your working card is salmon

Please return the **completed** TANF application in person or by mail to our location at:

**Physical Address:** 133 N. Court Street Wampsville (1st floor of the Department of Human Services Building-
drop box (blue) is outside
**Mailing Address:** P.O. Box 609 Wampsville, NY 13163

**NO LATER THAN FRIDAY, JUNE 4th 2021**
Please feel free to call me at 315-363-2400 if you have any questions about this year’s program.

Sincerely,

Jenny Buckley
Workforce Development Counselor

Scott Ingmire, Director
Jamie Kowalczyk, Assistant Director
Department of Planning and Workforce Development
P. O. Box 606, Wampsville, NY 13163
(315) 366-2376 Voice (315) 366-2742 Fax
scott.ingmire@madisoncounty.ny.gov

Ellen Bowe, Workforce Development Supervisor
Madison County One-Stop Career Center
PO Box 609, Wampsville, NY 13163
(315) 363-2400 Voice (315) 367-1300 Fax
ellen.bowe@madisoncounty.ny.gov

jamie.kowalczyk@madisoncounty.ny.gov
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.

   ☐ 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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>INCOME SOURCE: WAGES, SOCIAL SECURITY, etc.</th>
<th>AMOUNT</th>
<th>RECEIVED (Check One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>Yearly</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td>Weekly</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
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<td>6.</td>
<td></td>
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</tbody>
</table>

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.
MEDICAL INFORMATION FORM

THIS IS A VERY IMPORTANT FORM! We need you (parent/guardian) to fill this form out as completely and accurately as possible. This is the form we use to contact you (or your designated emergency person) if there is an emergency. It is imperative that we have accurate contact information. Also, this form will be used by any medical personnel that may need to treat your son/daughter.

Child’s Name ___________________________________________ Phone: ____________________________

(Last) (First) (MI)

Address ____________________________________________ (Street) (City) (State) (Zip)

Birth Date ____ Age ____ Height ____ Weight ____

School ___________________________________________ Grade Last Completed ______________________

***Name of person to be notified in case of emergency***

WE NEED A PHONE NUMBER WHERE WE CAN REACH SOMEONE AT ALL TIMES

Name ___________________________________________ Phone ________________________________________

Address ____________________________________________________________________________________

**Alternative Phone ________________________________________________________________

Medical Information

1. Does your child have any physical impairments or handicaps we should know about? Yes ______ No ______
   If yes, please explain _________________________________________________________________

2. Has your child had any operations? Yes ______ No ______ If yes, please explain (include year) _________________________________________________________________

3. Has your child had any serious injuries or illness? Yes ______ No ______ (include allergies, epilepsy, vision or hearing problems, heart disease, kidney disease, diabetes etc.). If yes, please explain _______________________________________________________________

4. Is your child allergic to bee stings? Yes ______ No ______ (If yes, an epi-pen must be carried at all times).

Immunization Information

(Give dates received or attach a copy of Immunization Record)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Booster Needed</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
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<td></td>
<td></td>
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<tr>
<td>Diphtheria</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<td></td>
<td></td>
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<tr>
<td>Rubella</td>
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</tbody>
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Emergency Information: Parental Endorsement for Emergency Care of Minors

If you have not reached your 18th birthday, your parent/guardian must sign below. In case of an emergency, permission is hereby granted to the most immediate available physician OR when traveling, the designated physician or consultant for the event, to treat ______________ who is ______ years old, to carry out essential diagnostic procedures, and to make necessary referrals to private physicians or other professional services.

______________________________________ OR ___________________________________________

Signature of Mother (or Legal Guardian) Signature of Father (or Legal Guardian)

Address ___________________________________________ (Street) (City) (State) (Zip)

Phone ___________________________________________