Participant Self-Certification
Supportive Services

Provider: ______________________ Service Location: ______________________

Funding Source: ☐ Adult ☐ Dislocated Worker ☐ Youth ☐ Other: __________

Participant Name: ______________________ State ID #: __________

NOTICE TO WIOA PARTICIPANT

This form is designed to facilitate the process for receiving Workforce Innovation and Opportunity Act (WIOA) funds for Supportive Services while participating in a WIOA activity. It requires your self-certification and, in some instances, documents to support your request. You are required to provide accurate and current information regarding all existing supportive service(s) that you are receiving or are scheduled to receive from any other federal, state, or local organization/agency.

Please check the appropriate box next to any financial assistance or employer benefits you are currently or will be receiving from any organization, agency, or employer.

Service	Currently Receiving	Will be receiving	N/A	Name of Organization	Amount	How often
Transportation	☐	☐	☐			
Childcare	☐	☐	☐			
Financial Support	☐	☐	☐			
Housing	☐	☐	☐			
Food Assistance	☐	☐	☐			
Medical	☐	☐	☐			
Vision Care	☐	☐	☐			
Scholarship/Educational Grant	☐	☐	☐			
Other:	☐	☐	☐			

Participant Self-Certification

I certify that the above information is true and correct to the best of my knowledge and understand false or misleading assertions or certification may result in the termination of WIOA services. If at any time I receive financial assistance or employer benefits of any kind from another organization, agency, or employer, I agree to immediately notify my WIOA Employment Readiness Specialist/Academic Career Advisor and submit a new certification to determine continued eligibility for receiving WIOA Supportive Services. I understand that failure to inform my Employment Readiness Specialist/Academic Career Advisor of changes occurring in my receipt of any other financial assistance not listed above may result in the loss of all WIOA services. I understand that upon receipt of funds for the purpose of childcare only, that I am responsible for the payment to the childcare provider and that the maximum total amount of WIOA Supportive Services I may receive is $1,000.00 during my lifetime.

______________________________________ Dated: __________

Participant Signature

Provider Staff Verification

I certify that I have verified all financial assistance amounts for all sources listed above.

______________________________________ Dated: __________

Employment Readiness Specialist/Academic Career Advisor Signature

This WIOA, Title I-financially assisted program/service is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to people with disabilities and/or limited English proficiency.