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SAN JOAQUIN COUNTY WORKNET EMPLOYMENT AND ECONOMIC DEVELOPMENT DEPARTMENT POLICIES AND PROCEDURES DIRECTIVE

DIRECTIVE NO.	EFFECTIVE DATE	APPLICABILITY	PAGE
D-58	July 1, 2020	CMD, GMD, FMD	1 of 5
SUBJECT: NEEDS-RELATED PAYMENTS FOR ADULTS AND DISLOCATED WORKERS REGISTERED IN TRAINING ACTIVITIES UNDER THE WORKFORCE INNOVATION AND OPPORTUNITY ACT (WIOA)			

I. PURPOSE

The purpose of this Directive is to establish policies and procedures for the provision of needs-related payments for adults and dislocated workers who are registered in training activities under WIOA Title 1.

II. GENERAL INFORMATION

Section 680.930 of the WIOA regulations describes needs based payments as providing financial assistance for the purpose of enabling individuals to participate in training authorized under WIOA.

Section 680.940 specifies the criteria for adults to receive needs related payments as follows:

Adults must:

- A. Be unemployed;
- B. Not qualify for, or have ceased qualifying for, unemployment compensation; and
- C. Be enrolled in a program of training services under WIOA sec. 134(c)(3).

Section 680.950 specifies the criteria for dislocated workers to receive needs related payments as follows:

Dislocated Workers must:

- A. Be unemployed, and:

1. Have ceased to qualify for unemployment compensation or trade readjustment allowance under TAA; and
 2. Be enrolled in a program of training services under WIOA sec. 134(c)(3) by the end of the 13th week after the most recent layoff that resulted in a determination of the worker's eligibility as a dislocated worker, or, if later, by the end of the 8th week after the worker is informed that a short-term layoff will exceed 6 months; or
- B. Be unemployed and did not qualify for unemployment compensation or trade readjustment assistance under TAA and be enrolled in a program of training services under WIOA sec. 134(c)(3).

Section 680.960 allows for needs-related payments to be made for participants who have been accepted into training within the next 30 calendar days. However, the local WIOA Board has chosen not to provide these payments while waiting for training. Additionally, the local WIOA Board has determined that they will not provide needs-related payments except by EXCEPTION ONLY. The initial determination of exception will be made by the case manager and approved by the CMD Division Manager.

It should be noted that for any participants granted this exception, Federal law prohibits taxation of these monies as no work was performed for the money, according to the IRS.

III. POLICY

It is the administrative policy of the EEDD that WIOA funds for needs related payments may only be provided when:

- A. The case manager determines that an exception exists that would not allow the participant to be provided training and that exception is justified in writing by the case manager and approved by the CMD Division Manager; and
- B. The requirements specified in Section 680.940 and 680.950 of the WIOA regulations and referred to in this directive have been met.
- C. Shall not utilize needs related payments to duplicate or enhance any financial support system that existed at the time of participant registration into the training program, regardless of the 30-day waiting period.

IV. PROCEDURE

- A. Determination of level of need

In accordance with Section 680.970, the local WIOA Board has set the level of payments for participants who may receive needs-related payments as specified in this directive as follows:

1. Adults

The level of needs-related payments may not exceed the equivalent weekly amount of the EEDD's annual 100% LLSIL for a family of one. The poverty level for family size is established for the adult program and must be divided by 52 weeks to determine a weekly poverty level.

2. Dislocated Workers

For dislocated workers, payments must not exceed the greater of either of the following levels:

- a. The applicable weekly level of the unemployment compensation benefit, for participants who were eligible for unemployment compensation as a result of the qualifying dislocation; or
- b. The poverty level for an equivalent period, for participants who did not qualify for unemployment compensation as a result of the qualifying layoff. The weekly payment level must be adjusted to reflect changes in total family income, as determined by Local WDB policies.

In both cases the payment level must be adjusted to reflect changes in total family income.

Further, it is the administrative policy that this department shall not utilize needs-related payments to duplicate or enhance any financial support system that existed at the time the participants enrolled into the training program.

B. Financial Analysis

The provisions for, and the amount of needs-related payments shall be recorded in the Individual Employment Plan (Attachment 1) under the budget sections. The individual determination for participant needs related payments by exception and the amount of such payments shall be based on the change between the participant's family monthly income and the family's monthly budget after enrollment into a training activity. If the participant enters work experience needs-related payments may be made by exception, if the wage does not meet or exceed the family's budget.

The needs-related payments must be documented on the Financial Assistance form showing how the amount authorized was determined.

C. Memorandum

The case manager will submit to the Division Manager for approval in memorandum format, a justification for the supportive services citing the following:

1. Purpose
2. Recommendation
3. Reason for Recommendation
4. Fiscal Impact -include hourly payment
5. Action to Be Taken

D. Modification

If it is determined, through continued assessment, that a participant's original budget should be modified to include "needs-related payment" because an exception exist the case manager will modify the plan by completing Attachment 2. The case manager will modify the original budget on the Individual Employment Plan. The justification for "need" in the modification must be in accordance with the policy set by the local WIOA board as set forth in this directive.

E. Fiscal Documentation

The following documentation must be submitted to the CMD Manager and the Executive Director and/or their designee for approval prior to forwarding the documentation to fiscal for processing of payments:

1. A copy of the updated financial analysis from the IEP dated and signed by the participant and the case manager;
2. A copy of the IEP Modification justifying the exception for needs-related payments when applicable.
3. Complete the IEP Needs-Related Payments and Financial Assistance Form (Attachment 3) that documents how the amount authorized was determined.
4. A copy of the Memorandum dated and signed by the case manager.
5. A Request for Goods and Services (RGS) (Attachment 4) specifying the justification utilized in the IEP, the grant and cost category of the needs-related payments are to be charged to, and the CMD Manager as well as the Executive Director and/or their designees signatures of approval.
6. Weekly Invoice System

It is the participant's responsibility to submit the approved invoice with the required signatures prior to the first and third Tuesday of each month. Invoices will be processed on the first and third Tuesday of each month by CMD support staff and late invoices will have to wait until the next processing date.

7. A monthly timesheet update from the participant with his/her signature in ink, the training signature and date is required. Case managers will review the information and make adjustments as needed.

V. QUESTIONS REGARDING THIS DIRECTIVE

May be referred to the Executive Director of EEDD via Managers or designee.

VI. UPDATE RESPONSIBILITY

The Executive Director of EEDD and/or designee shall be responsible for updating this directive, as appropriate.

VII. APPROVED



JOHN M. SOLIS
EXECUTIVE DIRECTOR

JMS: jl

- Attachment 1: Individual Employment Plan (IEP)
- Attachment 2: Financial Analysis
- Attachment 3: Needs-Related Payment & Financial Assistance Form
- Attachment 4: Request for Goods and Services – Supportive Services

INDIVIDUAL EMPLOYMENT PLAN (IEP)

NAME: _____
Last First

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: _____ CELL/MESSAGE PHONE #: _____

SSN: _____ EMAIL: _____

I. EMPLOYMENT GOALS

A. 1st Goal

1. ONET Title: _____

2. ONET Code: _____

3. WorkKeys Skill Level Requirement for 1st Goal (From WorkKeys Occupational Profiles Database)

Applied Mathematics: _____
Graphic Literacy: _____
Workplace Documents: _____

Client Scores

Applied Mathematics: _____
Graphic Literacy: _____
Workplace Documents: _____

WorkKeys waived – Provide justification:

4. Other Requirements (*examples: high school diploma, Class A license, Lift 50 lbs., type 45 wpm*)

B. 2nd Goal

1. ONET Title: _____

2. ONET Code: _____

3. WorkKeys Skill Level Requirement for 2nd Goal (From WorkKeys Occupational Profiles Database)

Applied Mathematics: _____
Graphic Literacy: _____
Workplace Documents: _____

Client Scores

Applied Mathematics: _____
Graphic Literacy: _____
Workplace Documents: _____

4. Other Requirements (examples: high school diploma, Class A license, Lift 50 lbs., type 45 wpm)

II. ACHIEVEMENT OBJECTIVES (Check all that apply)

Increase educational level necessary to meet employment goal and attain economic self-sufficiency through referral to partner agency basic skills training, GED program, or other appropriate program.

Increase WorkKeys skill level necessary to meet employment goal and attain economic self-sufficiency through enrollment into WIN Solutions basic workplace skills training.

Meet employment goal and attain economic self sufficiency through direct referral and placement with employer.

Enhance work readiness skills necessary to meet employment goal and attain economic self-sufficiency through enrollment into a work experience activity in the private and/or public/nonprofit sector.

Enhance occupational skills necessary to meet employment goal and attain economic self-sufficiency through enrollment into classroom training at a training provider listed on the Eligible Training Provider List (ETPL). Eligible training provider will be reimbursed for training through an Individual Training Account (ITA).

Enhance occupational skills necessary to meet employment goal and attain economic self-sufficiency through referral to partner agency classroom training program.

Enhance occupational skills necessary to meet employment goal and attain economic self-sufficiency through enrollment into On-the-Job Training (OJT) program. Employer will be reimbursed for extraordinary costs associated with training through an OJT agreement.

Other achievement objective:

Other achievement objective:

Participant Signature

Date

EEDD Staff Signature

Date

VII. FINANCIAL ANALYSIS:

CLIENT NAME

[Redacted]

Number of individuals dependant upon your income

[Redacted]

MONTHLY RESOURCES:

- 1 Wages
- 2 Child/Spousal Support
- 3 Workmen's Comp./UI
- 4 SSI/SSP,SSA
- 5 TANF
- 6 Food Stamps
- 7 Other

[Redacted]

A. TOTAL MONTHLY RESOURCES

LIVING WITH FRIEND

\$ - A

COST OF LIVING:

[Redacted] Projected

[Redacted] Actual

1 HOUSING:

- Rent
- Telephone/Cellphone/Pager
- Gas/PG&E
- Water & Sewage
- Cable

[Redacted]

\$ - 1

2 FOOD:

- Groceries
- Lunch Money

[Redacted]

\$ - 2

3 CLOTHING:

- Self & Dependants
- Diapers

[Redacted]

\$ - 3

4 PERSONAL EXPENSES:

- Grooming
- Laundry/Dry Cleaning

[Redacted]

\$ - 4

5 MEDICAL:

- Medi-Cal recipient?
- Doctor/Dentist Bills
- Prescription/Medicine

[Redacted]

\$ - 5

6 TRANSPORTATION:

- Car Payment
- Car Insurance
- Gas, Oil, Upkeep
- License & Reg Fee

[Redacted]

\$ - 6

7 EDUCATION & RECREATION:

- Entertainment, Magazines
- Tuition, Books

[Redacted]

\$ - 7

8 CHILD SUPPORT PAYMENTS:

[Redacted]

\$ - 8

9 CREDIT CARDS, OUTSTANDING DEBTS

Institution

Balance

Monthly Payments

[Redacted]

[Redacted]

[Redacted]

\$ - 9

B TOTAL COST OF LIVING (Add items 1-9)

\$ - B

C BALANCE (A-B)

\$ - C



Needs-Related Payment & Financial Assistance Form

CalJOBS Application Number

Participant Name (Last, First)

PARTICIPANT INFORMATION (ensure that participant information for applicant is complete and up-to-date)

<input type="checkbox"/> Adult or Youth <input type="checkbox"/> Dislocated Worker <input type="checkbox"/> Special Grant	Address	City	State/ZIP	Primary Phone
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RATIONALE FOR NEEDS-RELATED PAYMENTS

Needs-Related Payments were requested by (insert participant name). (Insert participant's name) requires financial assistance in order to participate in (his/her/their) training activity. The weekly payment for this participant is (insert actual amount). Needs-Related Payments funds will be used to pay for this supportive service, and the participant has received a total of (\$000.00) in Needs-Related Payments year-to-date.

I certify I am:

- Unemployed
 Did not qualify for unemployment or have ceased to qualify for unemployment
 Enrolled and attending an ETPL approved training full time
 Unable to qualify for unemployment or Trade Readjustment Assistance under TAA
 Do not have other resources to support me while attending training
 Require income support to participate in full-time training

Documentation

- LLSIL attached
 UI history attached

Needs-Related Payments are provided up to \$250 per week for a participant lifetime maximum of \$2,000.

DISLOCATED WORKER

ADULT OR YOUTH

Weekly level of UI Compensation		Annual Poverty Level for Family Size	
Total Number in Family		Divided by 52 weeks	
Annual Poverty Level for Family Size		Total Needs-Related Payment	
Divided by 52 weeks			

Printed Name of Requesting Staff	Signature of Requesting Staff	Date
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My signature below indicates that I have been informed of and understand the information contained on this form. I understand that I am required to return proper receipts and/or documentation that are requested for the purchases and services that I have received. I understand that, if the required receipts and/or documentation in the amount listed above are not returned, there will be no additional supportive services provided to me. Additionally, I understand that the above mentioned supportive services are solely for the use of myself. All supportive services are only to be used for the intended purpose. Failure to comply with these policies will result in termination of assistance.

Printed Name of Participant	Signature of Participant	Date
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FOR MANAGER/ACCOUNTING USE ONLY

Is request reasonable, necessary, and allowable based on established local policies? <input type="checkbox"/> Yes <input type="checkbox"/> No	Request Outcome <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Check/Card Number (if applicable)
Printed Name of Accounting Staff	Signature of Accounting Staff	Date
Printed Name of Manager	Signature of Manager	Date



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REQUEST FOR GOODS AND SERVICES – SUPPORTIVE SERVICES

Need By: _____
 Request Date: _____
 Requested By: _____
 Approved By: _____

- WIOA Youth WIOA Adult WIOA D/W
 In-School
 Out-School Other

QTY	UNIT	DESCRIPTION (Give Size, Color, Name, Stock No., Sample)	ITEM COST	TOTAL COST	FMD USE ONLY RGS NO.
				\$0.00	
				\$0.00	
				\$0.00	
				\$0.00	
				\$0.00	
			Tax		

- Trans. Subsidy Tuition Training Supplies Books/Other Services Childcare

Vendor Name: _____
 Address: _____ Phone: _____
 City: _____ Zip Code: _____

Participant's Name: _____ Case No.: _____

Justification: _____

Cost Estimate: _____ \$0.00

For Calcard/Voucher Attach the Following:

- 2 Quotes Budget QCH

FMD USE ONLY

County Account No.: 6221024800

Method: 3

Pool: 999

4820 - 46 - _____ - _____ - _____

4851 - 46 - _____ - _____ - _____

4840 - 46 - _____ - _____ - _____

_____ - 46 - _____ - _____ - _____

- Calcard Petty Cash Voucher

Available: _____ Allowable/Proper Justification: _____ Date: _____



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RGS INSTRUCTIONS

NEED BY DATE: Enter the date the items are needed.

REQUEST DATE: Date the form is completed.

REQUESTED BY: The individual who is filling out this form **MUST PRINT** their name (and phone # please). This helps fiscal to contact the right person if any questions arise.

APPROVED BY: The Division Manager/Supervisor responsible for the applicable Grant **MUST** sign on this line.

FUNDING SOURCE: Check the applicable Grant and whether the Participant is a 30%/70%/In-School/Out-School recipient.

LOCATION: Please enter the Location where the goods/services will be used. (STKN, LODI, etc.)

DESCRIPTION: Please provide accurate, detailed information.

- A. Quantity - number ordered
- B. Unit - i.e., each, pkg., box, dozen
- C. Full Description of item ordered including: stock number; catalog name, item number/letter and page number; color and size if applicable. If more than one item is ordered, please include cost of each.
- D. Line Item Cost - total estimated cost of all units on this line (excluding tax).

TYPE OF SUPPORTIVE SERVICE: Check the appropriate box that best describes the type of supportive service.

VENDOR: Complete this portion entirely. Be sure to supply the Vendor's Federal ID# for first time purchases.

PARTICIPANT INFORMATION: Enter the Participant's full name and case number.

JUSTIFICATION: Why is this item/service needed? How will it be used? Where will it be used? This information provides supporting documentation that justifies the need for the supportive service.

COST ESTIMATE: Enter the estimated cost of the item/service. Round up to the next dollar. Include all known costs (tax, processing fees, etc.).

RPO SUPPORTING DOCUMENTATION: The following must be attached: Quote, Participant Budget and Participant QCH