

MARSHALL ABE
Referral Form From Welfare to Work Agency

Client Name: _____ Address: _____
SSN: _____ Date of Birth: _____ Telephone #: _____ Country of Birth _____

Ethnicity: Asian Black/Afro American Native American Pacific Islander Hispanic White

Household Information:

Head: Single Parent (# of Dependents _____) 2 Parents (# of Dependents _____) No dependents
Other: Dependent Group Quarters Living Alone

Other Information: Choose all that apply

Disabled Learning Disability Other _____ Displaced Homemaker Homeless
 Immigrant Refugee Visitor Citizen Non Citizen (Year you came to the US _____)
 Rural Resident (population less than 2000) Urban Resident (population more than 2000)

Employment: Employed Full Time Employed Part Time Unemployed/Seeking
 Unemployed/ Not Seeking Retired Unavailable for work Dislocated worker

Public Assistance: Yes - MFIP Yes - (other-GA, SSI) No

Educational Status: Last Grade Completed: _____ Do you have a diploma/GED/Degree? _____
Last School Attended _____ How did you hear about our program? _____
Primary Language: _____ Read _____ Write _____ Speak _____

Previous Occupations: _____

MFIP Case Worker: _____ Telephone No. _____

No. of required ABE hours in customer's plan: _____ Date to Begin: _____

Comments: _____

I _____ authorize the SW MN Private Industry Council and the Marshall Area Adult Learning Center to share information about me regarding _____. I have been informed of the intended purpose and use of the information. I have also been informed that the information provided will not be further released without my consent except that which pertains to State or Federal regulations that govern the activities of PIC and ABE.

I have been informed of the meaning of this release and my signature on it amounts to a waiver of any claim I might assert against any individual or organization.

Signature of Client (and parent if under 18 years of age)

Signature of ABE agent

Signature of PIC agent

Date