MASSHIRE GREATER NEW BEDFORD WORKFORCE BOARD

Thank you for registering for the HWH grant Healthcare Leadership Development/Supervisor Training program through Bristol Community College.

Since this is a State funded training program, the final step to process your registration is for the attendee to complete and return the CommCorp required application included in this packet. This includes:

- **Participant Confidentiality Statement and Release Form**
- **Health Care Hubs Participant Registration Form**

Please scan and return the form pages to jacqueline@mhgnb.com. If you have any questions or need assistance returning the application, please feel free to call Jacqueline Sylvia at 508.979.1504 x116.

Upon receipt of your application, we will confirm your seat. **Please note** that space is limited and your seat is not guaranteed until you receive this final confirmation.

MASSHIRE

SOUTHEAST REGION 6 WORKFORCE BOARDS

BRISTOL COMMUNITY COLLEGE

FREE ONLINE

Healthcare

Leadership Development/Supervisor

Training for HWH Grant Employer Partner Incumbent Workers

This customized Healthcare Leadership Development/Supervisor Training offered through Bristol Community College is for your potential organization leaders. The group will participate in 8 sessions with each session lasting 3 hours for a total of a 24-hour course. The teaching approach is very practical and 'hands-on' with case studies and 'homework' to do between training sessions so that the learning is action based and retained by the participant.

Topics will include:

1. Becoming a More Effective Leader
2. Holiday Critical Conversations
3. Managing Inclusion
4. Managing Multi-Generational Employees
5. Effective Performance Management & Developing Employee Skills
6. Building a Successful Team One Step at a Time
7. Building Advanced Coaching Skills
8. Managing Workplace Change Successfully in Healthcare

Starts Monday, April 4, 2022

Mondays from 9 am to Noon

Full online schedule as follows:

April 4, 11, 25
May 2, 9, 16, 23
June 6 class ends

Holiday no class April 18
Holiday no class May 30

This the final opportunity for your staff to take part in this grant funded training.

Space is limited! Register online today at:

https://masshiregreaternewbedford.com/leadership-training2/

COMMONWEALTH CORPORATION
Building skills for a strong economy.

This is a State-funded program. Attendees must submit a completed CommCorp application provided upon submission of initial online registration.

This project is funded by a Senator Kenneth J. Donnelly Workforce Success Grant (Workforce Competitiveness Trust Fund FY'20 Appropriation) through the Massachusetts Executive Office of Labor and Workforce Development and is administered by the Commonwealth Corporation.

MassHire Programs & Services are funded in part by US Department of Labor (USDOL) Employment and Training Administration grants as well as non-federal funded grants. (Additional details furnished upon request.)

Participant Confidentiality Statement and Release Form

By being able to show that people who attended training funded through the Workforce Competitiveness Trust Fund (the Fund) are working and earning more, Commonwealth Corporation and other interested groups, like employers, can make a good case to the state to ask for more money to fund future training programs.

We hope that you will be able to share your social security number with Commonwealth Corporation. *If so, please sign below*:

I, _____,
(Print your name)
understand that the training program I am about to enter is paid for by the state of Massachusetts through the Workforce Competitiveness Trust Fund. Commonwealth Corporation, which oversees the Fund for the state, needs information about the training program and people attending training classes to be able to report to the state on how well the whole program is working and whether it is meeting its goals.

I understand that all information that I give to project staff about myself will be kept confidential. I also understand that project staff may ask my employer for information about my job and/or my pay and that this information will be kept confidential. Any other information about me, such as information from interviews, tests, reports from career counselors or other sources, will also be kept confidential and will only be used by HealthCare HUBs staff to report on the whole program. Any information that can be connected to my name cannot be given out to anyone else without my permission.

I understand that, as part of the training program funded by the Workforce Competitiveness Trust Fund, Commonwealth Corporation will be collecting confidential information about me and my participation in the program. I have read and understood the above statement and give Commonwealth Corporation permission to collect and use my information and give permission for my employer to release job and/or wage information according to the statement above.

I understand that by giving my social security number on this form, I give Commonwealth Corporation permission to use this number to get information on the results of the Workforce Competitiveness Trust Fund. I understand that this information will only be used to obtain state employment information to evaluate the Workforce Competitiveness Trust Fund projects and that my identity (name, address, etc.) will not be connected to the information obtained by the state.

_____ _____
(Sign your name) ***(Date)***

Health Care HUBs PARTICIPANT REGISTRATION FORM - *REQUIRED*

CONFIDENTIAL DATA: FOR OFFICIAL USE ONLY

1. FIRST NAME | MIDDLE NAME | LAST NAME

2. DATE OF BIRTH
____ ____ / ____ ____ / ____ ____ ____ ____
Month Day Year

3. SOCIAL SECURITY NUMBER
____ ____ ____ ---- ____ ____ --- ____ ____ ____ ____

4. EMAIL ADDRESS

5. PHONE NUMBER
(____ ____ ____) ____ ____ ____ -- ____ ____ ____ ____

6. STREET ADDRESS

7. CITY/TOWN

8. STATE
MASSACHUSETTS

9. ZIP CODE

10. WHAT IS YOUR CURRENT EMPLOYMENT STATUS?
_____ EMPLOYED _____ UNEMPLOYED

11. IF UNEMPLOYED, HOW MANY WEEKS HAVE YOU BEEN UNEMPLOYED DURING THE LAST YEAR? ____ ____

IF YOU ARE CURRENTLY EMPLOYED, PROVIDE INFORMATION ON CURRENT JOB. IF YOU ARE UNEMPLOYED, PLEASE SKIP TO QUESTION #18

12. NAME OF EMPLOYER

13. EMPLOYER'S CITY/TOWN

14. DESCRIBE YOUR EMPLOYER'S TYPE OF INDUSTRY OR WHAT YOUR COMPANY DOES.

15. JOB TITLE / DESCRIPTION

16. HOURLY WAGE ($/HOUR)
$ ____ ____ . ____ ____

17. AVERAGE HOURS PER WEEK
____ ____ . ____

FOR THE FOLLOWING QUESTIONS: IF YOU CHOOSE NOT TO DISCLOSE, PLEASE LEAVE BLANK

18. I IDENTIFY MY GENDER AS
_____MALE _____FEMALE _____OTHER

19. I IDENTIFY MY ETHNICITY AS
_____ HISPANIC OR LATINO (OF ANY RACE) _____ NOT HISPANIC OR LATINO

20. I IDENTIFY MY RACE AS *(CHECK ALL THAT APPLY)*
_____ AMERICAN INDIAN / ALASKA NATIVE
_____ ASIAN
_____ BLACK / AFRICAN AMERICAN
_____ NATIVE HAWAIIAN / PACIFIC ISLANDER
_____ WHITE
_____ SOME OTHER RACE

21. DO YOU HAVE A DISABILITY?
_____ YES _____ NO

22. CITIZENSHIP

_____ US CITIZEN

_____ ELIGIBLE NON-US CITIZEN

23. WERE YOU BORN IN THE UNITED STATES?

_____ YES _____ NO

24. VETERAN STATUS

_____ GULF WAR ERA VETERAN

_____ OTHER VETERAN _____ NONE

25. PRIMARY LANGUAGE SPOKEN AT HOME?

_____ ENGLISH (Skip to #27)

_____ OTHER (Complete #26)

26. IF NOT ENGLISH, WHAT IS YOUR PRIMARY LANGUAGE?

27. UNEMPLOYMENT INSURANCE STATUS

_____ U.I. CLAIMANT

_____ U.I. EXHAUSTEE

_____ NEITHER

28. ARE YOU RECEIVING ANY OF THE FOLLOWING PUBLIC ASSISTANCE OR BENEFITS? (*CHECK ALL THAT APPLY)*

_____ SSI (SUPPLEMENTAL SECURITY INCOME) _____ SSDI (SOCIAL SECURITY DISABILITY INSURANCE) _____ VETERAN'S BENEFITS

_____ TAFDC (TRANSITIONAL AID TO FAMILIES) _____ EAEDC (EMERGENCY AID) _____ WIC (WOMEN, INFANTS AND CHILDREN)

_____ SNAP (SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM) _____ MASSHEALTH _____ REFUGEE CASH ASSISTANCE

29. DO YOU RECEIVE A HOUSING SUBSIDY? _____ YES _____ NO

IF YES, WHAT TYPE OF HOUSING SUBSIDY DO YOU RECEIVE? *(CHECK ALL THAT APPLY)*

_____ MASSACHUSETTS RENTAL VOUCHER PROGRAM (MRVP) _____ FEDERAL SECTION 8 VOUCHER PROGRAM

_____ SUBSIDIZED UNIT FROM STATE PUBLIC HOUSING PROGRAM _____ SUBSIDIZED UNIT FROM FEDERAL PUBLIC HOUSING PROGRAM

_____ NOT SURE OF SOURCE

30. DO YOU RECEIVE A CHILD CARE SUBSIDY? _____ YES _____ NO

IF YES, WHAT TYPE OF CHILD CARE SUBSIDY DO YOU RECEIVE? *(CHECK ALL THAT APPLY)*

_____ THE DEPARTMENT OF EARLY EDUCATION AND CARE (EEC) _____ THE DEPARTMENT OF CHILDREN AND FAMILIES (DCF)

_____ THE DEPARTMENT OF TRANSITIONAL ASSISTANCE (DTA) _____ HEAD START _____ NOT SURE OF SOURCE

31. FAMILY SIZE – Include yourself (not less than 1)

32. YEARLY FAMILY INCOME

_____ $0 to $25,520
_____ $25,521 to $34,480
_____ $34,481 to $43,440
_____ $43,441 to $52,400
_____ $52,401 to $61,360
_____ $61,361 to $70,320
_____ $70,321 to $79,280
_____ $79,281 to $88,240
_____ More than $88,240

33. SELECT HIGHEST LEVEL OF SCHOOLING THAT YOU HAVE COMPLETED

_____ LESS THAN HIGH SCHOOL DIPLOMA
_____ HiSET / GED / HIGH SCHOOL EQUIVALENCY
_____ HIGH SCHOOL DIPLOMA
_____ SOME COLLEGE, NO DEGREE
_____ ASSOCIATE'S DEGREE
_____ MASTER'S DEGREE AND ABOVE
_____ BACHELOR'S DEGREE
_____ OTHER POSTSECONDARY TRAINING

34. ARE YOU A SINGLE PARENT?

_____ YES _____ NO

I hereby certify and attest that the information stated above is true and accurate. I acknowledge that the information on this application may be used for evaluation purposes by Commonwealth Corporation to aid in the implementation of the WCTF.

APPLICANT SIGNATURE

DATE

EQUAL OPPORTUNITY EMPLOYER/PROGRAM - AUXILIARY AIDS AND SERVICES ARE AVAILABLE UPON REQUEST TO INDIVIDUALS WITH DISABILITIES

STAFF USE ONLY

PROGRAM ENROLLMENT DATE: ____ ____ / ____ ____ / ____ ____ ____ ____
Month **Day** **Year**

PROGRAM COMPONENT: ___

PLEASE REMEMBER TO ENTER THIS INFORMATION INTO THE APRICOT DATABASE AND UPLOAD THIS FORM TO THE INDIVIDUAL'S FOLDER.

WCTF20 HEALTHCARE HUBS PARTICIPANT REGISTRATION FORM INSTRUCTIONS

PARTICIPANT BASIC INFORMATION

Name: Enter your first name, middle name (or initial) and last name.
Date of Birth: Enter your date of birth in the following month/day/year format: mm/dd/yyyy.
Social Security Number: Enter your 9-digit Social Security Number.
Email Address: Please provide an email address where project staff may contact you. If you do not have an email address, please leave this blank.
Phone Number & Address: Please provide current phone number and address where project staff may reach you.

PARTICIPANT EMPLOYMENT INFORMATION

What is Your Current Employment Status: Select "Employed" if you are currently employed and "Unemployed" if you are currently not employed.
How Many Weeks Unemployed During Last Year: If your current employment status is unemployed, list the number of weeks in which you were unemployed during the last year. If unsure of the exact number, please estimate as best you can. If you did not work at all in the last year, then enter 52.
Name of Employer: If employed, list the name of your current employer. (If unemployed, leave blank.)
Employer City: If employed, list the city that your current employer is located. (If unemployed, leave blank.)
Industry Sector: If employed, select the type of industry for your employer or describe what your company does. (If unemployed, leave blank.)
Job Title/Description: If employed, list your job title at your current employer. (If unemployed, leave blank.)
Hourly Wage: If employed, list your hourly wage at your current employer. (If unemployed, leave blank.)
Average Hours Worked Per Week: If employed, list the average number of hours you work per week. (If unemployed, leave blank.)

PARTICIPANT DEMOGRAPHIC INFORMATION and OTHER CHARACTERISTICS

*The following questions on demographic characteristics and on family income and public assistance & benefits are collected only for informational purposes to aid in the implementation and evaluation of the WCTF. ***If you choose not to disclose information on any question, please leave blank.*

Gender: Select either male or female or non-binary/non-conforming.
Ethnicity: Select your ethnicity based on the following descriptions:

- **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- **Not Hispanic or Latino:** A person not meeting the above definition.

Race: Check all that apply. Select your race based on the following descriptions:

- **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American:** A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Some Other Race:** Select this choice if you are of a race other than those described above.

Disability: Please check YES if you have a disability and NO if you do not have a disability. Under the Americans with Disabilities Act, a disability is a physical or mental impairment that substantially limits one or more of the person's major life activities.
Citizenship: Select US CITIZEN if you are a U.S. Citizen and ELIGIBLE NON-US CITIZEN if you are not a U.S. Citizen.
Were you born in the United States: Please check YES if you were born in the United States and NO if you were not born in the United States.
Veteran Status: Veteran is any person who has actively served in the U.S. Armed Forces, including reservists called to regular active duty & full time National Guard duty. Select GULF WAR ERA if you served at any time during the period beginning August 1990 and OTHER VETERAN if you served in an earlier period.
What is Your Primary Language Spoken at Home: Select ENGLISH if that is the language you speak at home or select OTHER if your language is not English. *If primary language is English, skip to the Unemployment Insurance question.*
Primary Language Other than English: Please list the primary language you speak at home. Leave blank if your primary language is English.
Unemployment Assistance: Please select UI CLAIMANT if currently receiving UI benefits and UI EXHAUSTEE if you have exhausted all UI benefit rights.
Benefits: Select any public assistance benefits that you are currently receiving. Please check all that apply.
Housing subsidy: means you are only required to pay a portion of your housing costs.
Child Care subsidy: means you are only required to pay a portion of your childcare costs or have all costs paid for through a voucher.
Family Size: Please indicate the number in your family, including yourself. A family is a group of two or more people who live in the same home and who are related by birth, marriage, or adoption. If you are a single individual, the size of family is "1."
Yearly Family Income: Please check the income level for the combined yearly family income for all of the family members counted in previous question.
Highest Level of Schooling that you have completed: Please select your highest level of schooling that you have completed.
Single Parent: Check YES if you are an individual who is unmarried or legally separated from a spouse and has a minor child or children for which you have either custody or joint custody. The definition of single parent also includes single pregnant women.
Applicant Statement: Applicant statement certifies that (a) the information the applicant has given is accurate, and that (b) the applicant has acknowledged that information collected during the application process may be used for evaluation purposes by the Commonwealth Corporation.
Applicant Signature & Date: Applicant must sign and date to verify the accuracy of the information given at time of intake and eligibility determination.

Staff Use Only: This section is reserved for program staff and is not to be completed by the applicant.
Program Enrollment Date: Provide the start date of the participant's program enrollment.
Program Training Component: Provide the name of the training program component as described in the plan for the grant.

COMMONWEALTH CORPORATION
Building skills for a strong economy.

1. The Healthcare HUB programs are funded by the state appropriation for the Workforce Competitiveness Trust Fund (WCTF) a State run program.

2. WCTF programs are administered by CommCorp on behalf of the Executive Office of Labor and Workforce Development. Participant tracking is accomplished through CommCorp's Sector Program Database which uses Social Solutions Apricot software.

3. CommCorp has an agreement with DUA to do UI wage record matching for post-program performance.

4. The Apricot system does not use SSN as a tracking ID for participants. SSN is entered and then hidden; no subsequent data entry screen nor any reports/listings use or display the SSN.

5. Information on labor force status and current employer are collected for information purposes only. It is not a formal eligibility item requiring documentation. The information is usually informally verified through the assessment and selection process but just not a formal documentation/employer verification process.

Q: Why does CommCorp ask for a participant's SSN?
Because the Healthcare Workforce Hubs grant is funded through the Workforce Competitiveness Trust Fund, it follows different rules and regulations than other programs. As a state-funded program, we have an agreement with the Department of Unemployment Assistance to report on the performance of WCTF-funded programs.

Q: How does CommCorp safeguard a participant's SSN?
When a participant signs the Participant Registration Form, the information provided on the form is held confidentially by the training project staff and Commonwealth Corporation. The information included on the Participant Registration Form, including SSN, is manually entered by a project staff member into a participant tracking database called Apricot bySocial Solutions. A hardcopy of the completed forms are then scanned and uploaded to Apricot as a PDF file.
Once the SSN is entered, it is then hidden by Apricot, so it is not displayed or seen on any other data entry screen or inany reports/listings generated by Apricot.

Q: Why is it important to ask participants to share and release permission for CommCorp to use their SSNs?
We need the participant's SSN to conduct wage record matching that demonstrates whether the WCTF-funded programs had a positive impact on the participant. This process enables us to make the case for the value of WCTF-funded programs and make the strong case for additional training program funding. Without access to SSNs, we are unable to demonstrate the impacts of training programs on its participants and therefore are unable to provide strong evidence for sustained funding for training programs.