DENVER DEPARTMENT OF HUMAN SERVICES
STATE DIVERSION FORM
(This form should be read aloud to the applicant/recipient.)

I (Applicant/Recipient) _____ SSN _____ agree:

I (Applicant/Recipient) _____ SSN _____ agree:

- That I have had available food stamp, medical, child care, and child support services explained to me. I know I have the right to apply for these services.
- To accept a Diversion payment in the amount of $_____ from Denver County Human Services to meet immediate needs instead of receiving a TANF monthly assistance payment(s) for the following issuance period(s): _____ _____.
- I agree to participant in the workforce development related activities as designated on the Individual Responsibility Contract developed in conjunction with my Case Management Coordinator.

To have my ongoing TANF cash assistance discontinued effective_____ or to have my application for ongoing TANF cash assistance denied effective _____.

I UNDERSTAND THAT:

- If I reapply for monthly TANF cash assistance within the next _____ months, I understand that my application will be reviewed by the Diversion Exception Committee.
- My reapplication for TANF cash assistance during the above time period will not be approved unless the Diversion Exception Committee determines that my reapplication is due to circumstances beyond my control as designated in the Denver County Diversion Program Policy (97-1-DVR).
- I understand that if I do not use these funds to meet the needs requested, the funds may be recovered.
- I have appeal rights
- I will remain in contact with the Child Support Enforcement Division for help in collecting child support, if applicable.

In order to remain eligible for food stamp, child care, and/or medical services I need to immediately report any changes to my household composition, income, address, etc.

Under penalty of perjury, I hereby certify by signing this form that I am saying the information I gave in my application for a State diversion is correct to the best of my knowledge and belief and that each person who is eligible to participate listed on this application is a United States citizen or lawful alien.

_____ _____
Participant's Signature/Date DWD Worker Signature/Date

_____ _____
Other Participant's Signature/Date DWD Supervisor Signature/Date

DW-164

COLORADO WORKS
INDIVIDUAL RESPONSIBILITY CONTRACT (IRC)

Name	Case Number -	Social Security Number	Telephone Number ( ) -

Employment Goal(s):

Identified strengths and skills for goal attainment: _____

Barriers for goal attainment (plans to overcome barriers addressed in next section): _____

Other family needs: _____

☐ **Job Ready (Level I)**	☐ **Job Ready Transitions (Level II)**
☐ **Employability Stabilization (Level III)**	☐ **Employment Alternatives (Level IV)**

All planning is directed toward achieving the participant's employment goal and must be related to the participant's strengths and overcoming of barriers.
All supportive services from the agency are authorized for activity in the plan and if available and needed.

Participant Activities	Begin/ End Dates	Hours	Agency Service
STATE Diversion:			WFA request will
			be approved or
			denied by
			Administration only
			Amount approved
			may be adjusted
Provide Information with in 5 business days:			from amount
			requested
			WFA amount will
Attend one 2hour Financial Class @ 1391 Speer Blvd			be based on need
Suite 510 contact Bobbi Novinski for dates, times and parking			
Code 720 865 5580			Failure to provide
If employed must maintain employment to sustain self-sufficiency			requested information will result in a denial
Provide verification of job equipment needed(uniforms, tools, etc.) to obtain or sustain employment			Approval is not guaranteed
			This payment may
			affect your food stamps
			Medicaid and child care

The lifetime limit for receiving TANF Basic Cash Assistance is 60 months. To receive TANF past 60 months, an application for grant extension must be filed and approved by the county.	**Lifetime Clock in Months:**		
			60
	Used	**Remaining**	Limit

Each party, by signing this Individual Responsibility Contract, assumes responsibility for the activities or services he/she will be required to pursue and/or provide within the accompanying timeframes.

_____ Participants Signature and Date

_____ Worker Signature and Date

Distribution: Original – Casefile Copy – Participant

COLORADO WORKS
INDIVIDUAL RESPONSIBILITY CONTRACT (IRC)

Name	**Case Number**	**Social Security Number**	**Telephone Number** ( ) -

PROVISIONS

1. This IRC is to be considered as a contract between the participant and the Denver County Denver Department of Human Services that contains Terms and Conditions governing the participant's receipt of assistance under the Colorado Works Program.
2. No individual is legally entitled to any form of assistance under the Colorado Works Program.
3. Failure to comply with the terms and conditions of this IRC may result in sanctions, including but not limited to termination from any cash assistance.
4. This IRC shall be limited in scope to matters relating to securing and maintaining training, education or work.
5. Either the Denver Department of Human Services or the participant may request a modification of this IRC at anytime.

RESPONSIBILITIES

As a Colorado Works participant, your participation and cooperation are required. You are responsible to notify your worker if any changes occur in your circumstances which might affect your cash assistance. As a Colorado Works participant, you are required to:

- Keep all appointments with your worker.
- Respond to any request from the county department or participating agency regarding your employment status.
- Participant in assessments to determine your level of job readiness.
- Report for and participate in any employment or education activity agreed to by you and your worker.
- Notify your worker immediately of any or all of the following:
  - A change in your employment status.
  - Being out of town and not available for work, job referral or training sessions.
  - Emergency situations which prevent you from participating in assigned activities.
  - Absence from any scheduled classes of job-related activities and
- Accept and maintain appropriate employment.

RIGHTS

You have the right to file a grievance or complaint if you believe that you have been discriminated against on the basis of you age, race, color, creed, sex or previous national origin, or if you disagree with your worker's assignment or decision. Your worker will assist you in filing a grievance or complaint.

You have the right to look for work on your own and accept a job if offered.

You have the right to dispute resolution at the county department if you are not satisfied with actions affecting your assistance or work participation. You have the right to appeal to the state department if the dispute is not resolved. Your worker will assist you in filing a request for dispute resolution or state appeal.

My rights and responsibilities have been explained to me and I understand my participation requirements in the Colorado Works Program as outlined above. I understand that I am required to participate in the activities listed and for the number of hours per week designated in my IRC. I also understand that if I move to another county, this IRC may be voided.

_____

Participant Signature and Date

As a representative of this agency, I have carefully explained the participant's rights and responsibilities and acknowledge the responsibilities of the agency. A signed copy of the IRC has been provided to the participant.

_____

Worker Signature and Date

Distribution: Original – Casefile Copy – Participant

DOMESTIC VIOLENCE SCREENING DOCUMENT

COUNTY WORKER: Begin by asking the applicant/participant the questions below. You can say, "The information you provide us is very important, because there are time limits on how long you can receive benefits. It is important for us to discuss anything that will make it difficult or prevent you from working. If we know this, we can develop with you, a safe and workable plan. We can also help you find the services you need to stay out of danger. Your information will not affect your eligibility for assistance and everything you say will be confidential. However, if you tell me that a child(ren) is being abused, I am required by state law to report that information to child protective services."

NAME: _____ M/F (circle one)

CASE NUMBER: _____ SSN: _____

1. Are you or have you been, in a relationship where your past ☐ or current ☐ partner (spouse, boy/girlfriend) has been physically, sexually, emotionally or verbally abusive? For example:

☐ **Yes** ☐ **No** **Pushed, shoved, or slapped?**
☐ **Yes** ☐ **No** **Kept away from family and friends?**
☐ **Yes** ☐ **No** **Hit, kicked, or punched?**
☐ **Yes** ☐ **No** **Destroyed your possessions such as car, clothes, furniture, family photos, or hurt your pets?**
☐ **Yes** ☐ **No** **Threatened to take your child(ren) away from you?**
☐ **Yes** ☐ **No** **Monitored your actions, like listening to calls, following you, checking your mileage?**
☐ **Yes** ☐ **No** **Stalked you, like driving by your work, your house, showing up unexpectedly, or making a lot of phone calls to your work?**
☐ **Yes** ☐ **No** **Forced to do anything sexual you did not want to do or raped you?**
☐ **Yes** ☐ **No** **Told you that you are worthless, called you names or made you feel bad about yourself?**

Record the person's experiences below

_____

_____

_____

1. When did this happen? In the last month? In the last 6 months? _____

_____

2. Is the abuser a parent of any of your children? Yes No If yes, who? _____

_____

3. Are you afraid of this person? Yes No If so, describe? _____

_____

4. Have you ever called the police because of this person? Yes No If yes, why?

_____

5. Have you ever requested or gotten a Restraining Order? Yes No If yes, has the Restraining Order ever been violated? Yes No If yes, how many times? _____

_____

6. Did this person ever prevent you from working or attending a training program or harass you at your workplace, or prevent you from receiving medical treatment? Yes No If yes, explain? _____

_____

7. Does this person use alcohol or drugs? Yes No If so, what? _____

_____

8. Does this person own any weapons? Yes No If yes, what kind? Have they ever threatened you with a weapon? Yes No _____

_____

9. Has this person ever displayed cruelty to animals? Yes No If yes, when was the last time and what happened? _____

_____

10. Has this person ever threatened to hurt or kill himself or herself? Yes No If yes, when was the last time? _____

_____

11. Has this person ever threatened to hurt or kill you, your child(ren), or a family member? Yes No If yes, when was the last time? _____

_____

If you have answered "No" to these questions, **please let us know at any time if you feel that you or your child(ren) are in danger.** I am giving you a Resource Packet that includes places to call and information on how to stay safe.

COLORADO WORKS
DOMESTIC VIOLENCE WORK REQUIREMENT WAIVER

County Department: _____ Applicant Name: _____
State ID: _____ Household No.: _____

Applicant Acknowledgment (Check all those that apply)

☐ I have received the "Domestic Violence and Colorado Works: Information That Can Help You Succeed in the Colorado Works Program" notification and information that explains how to obtain domestic violence services and apply for a waiver from the Colorado Works' State Work Requirements.

☐ The county worker has explained the process for applying for this State Work Requirements Waiver.

☐ I am applying for a **Domestic Violence Work Requirement Waiver.**

_____ _____ _____
Signature of Applicant Print Name Date

_____
Home Address

(____)_____ _____
Telephone Number where it is safe to contact you. Time of day safe to call.

County Acknowledgment

☐ I certify that the participant and county worker agree on the terms and conditions of the Individual Responsibility Contract (IRC) as it relates to domestic violence.
(If this box is checked, keep this document in the case record).

☐ Work requirements have been waived under the Family Violence Option until _____. This waiver must be reviewed at least every 6 months. (If this box is checked, you must enter "DV" component in CACTIS for the duration of the waiver of any work requirements).

☐ I certify that the county department of human/social services has reviewed and denied the participant's "good cause" request for a waiver from work requirements based on county policy: I certify that the applicant/participant's waiver from work requirements has been forwarded to the State Department of Human Services. (Please include a copy of the screening document as well as all items listed in CDHS staff Manual Volume III Regulations, 3.602.8., including county policy regarding work requirement waivers).

_____ _____
Signature of County Worker Date

Family Stabilization Assessment

Name _____ Address _____ Phone _____

Adults? _____ Children? _____ Ages _____

Have you applied for a Diversion before? _____ Type of Diversion? State County. If so, where? _____ When? _____ Purpose? _____ Amount $_____

Amount requesting today? $_____

Specific need today? _____

_____

Other resources your tried before coming here today _____

If you have recently moved, did you get your deposit back?_____ Amount: $_____

If so, what did you use this money for? _____

Are you currently homeless? ____ How long? ____ What are your current living arrangements? (family, friends, Section 8, transitional, etc.)_____

_____Do you share expenses with anyone?_____

What is your share? _____Describe your rental history_____

_____

****

Explain your work history_____

_____

_____

Are you currently employed?___ Start date _____ Termination date_____

Monthly earned income $_____ Hourly rate $_____ Hours per week_____

How often are you paid? _____ Unearned Income _____ Type_____

Who receives it? _____ Has this income recently stopped/changed?_____

If so, when? _____ Child Support $_____ Is it court ordered: _____

If no longer employed, where was your last employment _____

Why did you leave?_____

What was the amount of your last check? $_____ When did you receive it?_____

What did you use this income for? _____

Rev. 7/07

Do you have a checking or savings account? ____ What is the account balance? _____

Do you own a vehicle? _____

How much is still owed? $_____ Type of vehicle _____ Year? _____

Current CO ID/drivers license? _____ Car insurance _____

Car registered in your name? ____ Requesting repair? ____ Do you own stocks, bonds or property? _____ If so where? _____

Do you receive Food Stamps? Y N Do you receive Medicaid? Y N

Do you receive WIC Y N have you recently been evicted? Y N

Do you have a shut off notice for Xcel Energy? Y N

Did you receive a LEAP payment this year? Y N

Are you pregnant? Y N Is there anyone in your home disabled? Y N

Were you told by a Social Worker to apply for assistance? Y N

Monthly Obligations

Rent/Mortgage	$_____	*Total Monthly net income*	_____
Utilities	$_____	*Minus*	
Phone	$_____	*Total Monthly Expense*	_____
Daycare	$_____	*Equals*	_____
Groceries	$_____		
Household items	$_____		
Transportation	$_____		
CCAP Parental fee	$_____		
Misc. bills	$_____		
Total	$_____		

Are there any of the following that you may need? Circle all that apply.

GED Training Employment Re-Certifications Job Search Uniforms/Tools

Hygiene supplies Formula Diapers Child Support Parenting support Child Care

Help with getting medications Counseling

Signature _____ Date _____

CONSEQUENCES OF WFA/DIVERSION

WFA (*WORKING FAMILY ASSISTANCE*) PAYMENTS

_____ This Diversion may effect food stamps and/or other benefits.

_____ Your request for WFA may not be approved.

_____ You can receive 2 Diversions in a lifetime: Limited to 2 per year.

_____ A Recovery may be established for money not used for requested need.

_____ You can not receive TANF(*Temporary Assistance for Needy Families*) or any other services funded by TANF and a WFA in the *same* month.

_____ Based on your request, you may need to exercise other options, like a referral to CCH(*Colorado Coalition for the Homeless*), an upgrade in employment etc...

STATE DIVERSION (*DIVERSION*):

_____ This Diversion may effect Food Stamps and /or other benefits.

_____ A recovery may be established for money not used for requested need.

_____ Your request for Diversion may not be approved.

_____ You cannot receive TANF and Diversion in the same month.

_____

Applicant Signature *Date*

_____

Other Applicant Signature *Date*

Revised 2/20/02

DENVER DEPARTMENT OF HUMAN SERVICES
ASSISTANCE RECORD OF CONTACT (ROC) WORKSHEET

CLIENT NAME	HOUSEHOLD #	SOCIAL SECURITY #

Note method of contact, dates, results of contact (including any action affecting eligibility and/or grant) and with whom contact was made

DATE:	
	Household composition - Diversion count 1st 2nd
	Amount requested -
	Type of diversion requested COUNTY/WFA STATE
	Specific Need -
	What occurred to create this need:

DW-214 (Rev 1/99)

City & County of Denver

Department of Human Services
Accredited by Child Welfare League of America Since 1949

1200 Federal Boulevard
Denver, Colorado 80204-3221
Phone: 720-944-3666
FAX: 720-944-2329

John W. Hickenlooper
Mayor

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)
MEDICAL ASSISTANCE (MEDICAID)
ELIGIBILITY CHECKLIST

_____ Date _____

_____ Household # _____

_____

_____

Please read the following information carefully. This form will tell you what documents are necessary to determine your initial or ongoing eligibility for TANF and/or Medicaid.

- ☐ Earned Income for the month(s) of: _____
- ☐ Social Security Number or Receipt of application for: _____
- ☐ Pregnancy Statement
- ☐ Immunization Records for: _____
- ☐ Unearned Income: Such as Social Security benefits, VA benefits, SSI, Child Support, Unemployment Compensation, Military Allotments.
- ☐ Checking and Savings Accounts (current statement from the bank)
- ☐ Savings Bonds, Trust Funds, Certificates of Deposit (CD), Stocks, etc.
- ☐ Real Estate Property
- ☐ Motor Vehicles
- ☐ Insurance Policies: Such as life, health, burial, etc.
- ☐ Proof of Relationship: Birth certificates for: _____
- ☐ Citizenship/Alien Status (both sides of card or naturalization papers)
- ☐ School Financial Aid
- ☐ Workman's Compensation
- ☐ Employment Verification (Employment Letter or Form DW-209)
- ☐ Employment Termination (Employment Letter or Form DW-209)
- ☐ Please come in to renegotiate your Individual Responsibility Contract (IRC). An appointment has been scheduled on _____. If you cannot keep this appointment please call me immediately to reschedule the appointment.
- ☐ Other: _____

This information must be received by _____. Failure to provide this information or attend your appointment could result in a denial, discontinuation or decrease of your benefits. If you are unable to return this information/documentation by the above date, you may contact your worker and request an extension of not more than ten calendar days.

_____ _____

County Worker Telephone Number