Missouri Department of Economic Development
Missouri Division of Workforce Development

SkillUP Employment or Training Information

☐ ABAWD
☐ VOLUNTEER
☐ REGAIN ELIGIBILITY

If participant gets Food Stamp benefits, or is attempting to regaining eligibility, and has taken part in work or training in the past 30 days:

- Fill out this form to show participant's work and/or training activities during the past 30 days. Complete as much of this form as you can.
- If there is information you are unable to attain, the Family Support Division (FSD) will contact the participant to obtain additional information. If the participant has questions, they must contact FSD at (855) 373-4636, or visit any FSD Resource Center.
- Attach copies of any papers that confirm participant's activities (such as pay-stubs or school schedule).

Job Center staff: Scan to FSD ABAWD Team and DWD Share Drive.

YOUR INFORMATION

NAME	PHONE NUMBER	DCN *(Required)*	LAST 4 DIGITS OF SSN

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

WORK ACTIVITY #1

NAME	PHONE NUMBER	START DATE	END DATE

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

CURRENT POSITION	AMOUNT EARNED PER PAY PERIOD BEFORE ANY DEDUCTIONS (I.E. TAXES)

PAY PERIOD (CHOOSE ONE)

☐ Monthly ☐ Twice a month ☐ Every 2 Weeks ☐ Weekly ☐ Other

TYPE OF WORK IF APPLICABLE (CHOOSE ONE)

☐ On-the-Job Training ☐ Work Study ☐ Americorps/Visa Stipend ☐ Tips or Bonus
☐ In Kind ☐ Self-Employment ☐ Commission

COMPLETE THE SECTION BELOW FOR EACH PAYMENT YOU HAVE RECEIVED IN THE LAST 30 DAYS

DATE CHECK RECEIVED	RATE OF PAY DO NOT INCLUDED TIPS OR SICK/VACATION PAY	TOTAL HOURS WORKED	EARNINGS BEFORE DEDUCTIONS	TIPS	SICK OR VACATION PAY	OVERTIME AMOUNT INCLUDED IN RATE OF PAY

WORK ACTIVITY #2

NAME	PHONE NUMBER	START DATE	END DATE

ADDRESS (STREET NAME AND NUMBER)	CITY	STATE	ZIP CODE

CURRENT POSITION	AMOUNT EARNED PER PAY PERIOD BEFORE ANY DEDUCTIONS (I.E. TAXES)

PAY PERIOD (CHOOSE ONE)

☐ Monthly ☐ Twice a month ☐ Every 2 Weeks ☐ Weekly ☐ Other

TYPE OF WORK IF APPLICABLE (CHOOSE ONE)

☐ On-the-Job Training ☐ Work Study ☐ Americorps/Visa Stipend ☐ Tips or Bonus
☐ In Kind ☐ Self-Employment ☐ Commission

COMPLETE THE SECTION BELOW FOR EACH PAYMENT YOU HAVE RECEIVED IN THE LAST 30 DAYS

DATE CHECK RECEIVED	RATE OF PAY DO NOT INCLUDED TIPS OR SICK/VACATION PAY	TOTAL HOURS WORKED	EARNINGS BEFORE DEDUCTIONS	TIPS	SICK OR VACATION PAY	OVERTIME AMOUNT INCLUDED IN RATE OF PAY

For additional information about Missouri Division of Workforce Development services, contact a Missouri Job Center near you.
Locations and additional information are available at jobs.mo.gov or (888) 728-JOBS (5627).

Missouri Division of Workforce Development is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Missouri Relay Services are available at 711.

NAME (LAST, FIRST, MI)	**Last 4 SSN and DCN** *(Required)*

TRAINING AND/OR WORKSHOP #1

TRAINING PROVIDER NAME/DWD WORKSHOP NAME *(Required)*	NO. HOURS IN TRAINING PER MONTH	DATES TRAINING STARTS/ENDS
		START _____ END _____

ARE YOU RECEIVING ANY EARNINGS FROM TRAINING?	MO Job Center/WIOA/Partner Agency activity for participation in Employment and Training requirement.	IF TRAINING PROVIDED BY A COLLEGE, LIST NAME AND ADDRESS OF COLLEGE
☐ YES ☐ NO • IF YES, LIST AMOUNT $ _____		
FUNDING SOURCE *(Mark appropriate boxes)*		
SkillUP ☐ WIOA ☐ Financial Aid ☐ Self-Pay ☐	YES _____ NO_____	

TRAINING AND/OR WORKSHOP #2

TRAINING PROVIDER NAME/DWD WORKSHOP NAME *(Required)*	NO. HOURS IN TRAINING PER MONTH	DATES TRAINING STARTS/ENDS
		START _____ END _____

ARE YOU RECEIVING ANY EARNINGS FROM TRAINING?	MO Job Center/WIOA/Partner Agency activity for participation in Employment and Training requirement.	IF TRAINING PROVIDED BY A COLLEGE, LIST NAME AND ADDRESS OF COLLEGE
☐ YES ☐ NO • IF YES, LIST AMOUNT $ _____		
FUNDING SOURCE *(Mark appropriate boxes)*		
SkillUP ☐ WIOA ☐ Financial Aid ☐ Self-Pay ☐	YES _____ NO_____	

EXEMPTION

I AM NOT AVAILABLE TO WORK OR TRAIN BECAUSE

RECEIVING UNEMPLOYMENT INSURANCE BENEFITS: ☐ YES ☐ NO

OTHER SERVICES

LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
LIST ANY JOB CENTER SERVICES RECEIVED	DATE	NUMBER OF HOURS
		TOTAL HOURS

You must initial on each of these statements indicating that everything stated is true.

_____ • I understand that it is against the law to obtain or attempt to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

_____ • I authorize the Director of Family Support division or his/her appointee to investigate and verify these circumstances and statements.

_____ • I understand if I disagree with the decision concerning our eligibility, I may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

_____ • I understand that I must report any changes in circumstances within ten days of when they happen.

_____ • I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.

SIGNATURE OF APPLICANT	DATE

FOR INTERNAL USE ONLY

SKILLUP PROVIDER AGENCY AND CONTACT NUMBER	CITY
STAFF NAME	STAFF EMAIL