DELAWARE'S
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)
PROGRAM

CONTRACT OF MUTUAL RESPONSIBILITY

(Adult included in the grant)

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Delaware's Temporary Assistance for Needy Families (TANF) program helps people who get welfare by providing support systems and opportunities to help them get and keep employment. The program also helps ensure that those adults who are able to work get jobs as quickly as possible. In turn, TANF participants must accept responsibility to become self-sufficient and self-supporting. The program is based on partnership and shared responsibility between the client, DSS, and contractors throughout the community working together in the commitment to assist and prepare families for economic self-sufficiency.

The Contract of Mutual Responsibility (CMR) specifies the supports that the State will provide, and the responsibilities you have, to help you achieve self-sufficiency. The CMR also specifies the consequences for you if you do not comply with the requirements, and the outcomes that you can expect when the requirements are met. The CMR will help you to understand what you need to do to fully take advantage of the financial and other supports that TANF offers.

MUTUAL AGREEMENTS

I agree to:

- Work with my social worker to make this Contract of Mutual Responsibility.
- Take part in the activities assigned by my employment and training contractor for two weeks in a row before I can get a TANF check.
- Provide proof that I am doing what the contract says I must do.

The State and Contractors agree to:

- Help me to reach the goal of supporting myself.
- Help me to change this contract as the needs or situation of my family changes.

DELAWARE'S
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)
PROGRAM

CONTRACT OF MUTUAL RESPONSIBILITY

(Adult not included in the grant)

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Delaware's Temporary Assistance for Needy Families (TANF) program helps people to support children in their care by providing welfare for these children and other supports that may be needed by their caretakers. The program is based on partnership and shared responsibility between the children's caretakers, DSS, and contractors throughout the community working together for the benefit of the children for whom welfare is being provided.

The Contract of Mutual Responsibility (CMR) specifies the supports that the State will provide, and the responsibilities you have, to receive welfare benefits on behalf of the child(ren) in your care. The CMR also specifies the consequences for you if you do not comply with the requirements, and the outcomes that you can expect when the requirements are met. The CMR will help you to understand what you need to do to fully take advantage of the financial and other supports that TANF offers.

MUTUAL AGREEMENTS

I agree to:

- Work with my social worker to make this Contract of Mutual Responsibility.
- Take part in the activities listed in this contract.
- Provide proof that I am doing what the contract says I must do.

The State and Contractors agree to:

- Provide welfare for the support of the child(ren) in my care.
- Help me to change this contract as the needs or situation of my family changes.

DELAWARE'S
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)
PROGRAM

CONTRACT OF MUTUAL RESPONSIBILITY

(Adult counted but not included in the grant)

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Delaware's Temporary Assistance for Needy Families (TANF) program helps people to support children in their care by providing welfare for these children and other supports that may be needed by their caretakers. The program is based on partnership and shared responsibility between the children's caretakers, DSS, and contractors throughout the community working together for the benefit of the children for whom welfare is being provided.

The Contract of Mutual Responsibility (CMR) specifies the supports that the State will provide, and the responsibilities you have, to receive welfare benefits on behalf of the child(ren) in your care. The CMR also specifies the consequences for you if you do not comply with the requirements, and the outcomes that you can expect when the requirements are met. The CMR will help you to understand what you need to do to take full advantage of the financial and other supports that TANF offers.

MUTUAL AGREEMENTS

I agree to:

- Work with my social worker to make this Contract of Mutual Responsibility.
- Take part in the activities assigned by my employment and training contractor for two weeks in a row before my family can get a TANF check.
- Provide proof that I am doing what the contract says I must do.

The State and Contractors agree to:

- Provide welfare for the support of the child(ren) in my care.
- Help me to change this contract as the needs or situation of my family changes.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Single Adult Headed Families (48-month time limit, continuously on assistance):

Under TANF, cash benefits are limited to twenty-four (24) total months for households headed by an adult age 19 or over who can work and is included in the grant. Some parents who are not included in the grant are also limited to 24 total months. If you have not found a job at the end of this period, you can receive cash benefits for an additional twenty-four (24) months if you work or participate in the Work for Your Welfare Program.

You got benefits for _____ months. You have _____ months left.

After your family gets cash benefits for forty-eight (48) total months, you will not get more benefits unless you prove that there are reasons that you should continue to get benefits. In those cases, cash benefits are approved for a maximum of twelve (12) more months but only for the families in the Work for Your Welfare Program.

If you are a single parent and you have a child under 12 months of age you do not have to work or participate in employment and training activities. You may use this exemption for 12 months in your life time.

You used _____ months of this exemption. You have _____ months left.

BENEFITS ARE NOT TIME LIMITED
FOR PERSONS
WORKING
30 OR MORE HOURS PER WEEK

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Single Parent (48-month time limit, re-applying on or after Jan. 1, 2000)

In order for you to get TANF cash benefits you must either work or participate in the Work for Your Welfare Program. Under TANF, cash benefits are limited to forty-eight (48) months.

You got benefits for _____ months. You have _____ months left.

After your family gets cash benefits for forty-eight (48) total months, you will not get more benefits unless you prove that there are reasons that you should continue to get benefits. In those cases, cash benefits are approved for a maximum of twelve (12) more months but only for the families in the Work for Your Welfare Program.

If you are a single parent and you have a child under 12 months of age you do not have to work or participate in employment and training activities. You may use this exemption for 12 months in your life time.

You used _____ months of this exemption. You have _____ months left.

BENEFITS ARE NOT TIME LIMITED
FOR PERSONS
WORKING
30 OR MORE HOURS PER WEEK.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Two Parent Families (48-month time limit, reapplying on or after Jan. 1, 2000):

In order for you to get TANF cash benefits you must either work or participate in the Work for Your Welfare Program. Under TANF, cash benefits are limited to forty-eight (48) months.

You got benefits for _____ months. You have _____ months left.

After your family gets cash benefits for forty-eight (48) total months, you will not get more benefits unless you prove that there are reasons that you should continue to get benefits. In those cases, cash benefits are approved for a maximum of twelve (12) more months but for the families only in the Work for Your Welfare Program.

BENEFITS ARE NOT TIME LIMITED
FOR PERSONS
WORKING
30 OR MORE HOURS PER WEEK.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

Single Parent or Two Parent Family (36-month time limit, applying on or after Jan. 1, 2000):

In order for you to get TANF cash benefits you must either work or participate in the Work for Your Welfare Program. Under TANF cash benefits are limited to thirty-six (36) months.

You got benefits for _____ months. You have _____ months left.

After your family gets cash benefits for thirty-six (36) total months, you will not get more benefits unless you prove that there are reasons that you should continue to get benefits. In those cases, cash benefits are approved for a maximum of twelve (12) more months but only for the families in the Work for Your Welfare Program.

If you are a single parent and you have a child under 12 months of age you do not have to work or participate in employment and training activities. You may use this exemption for 12 months in your life time.

You used _____ months of this exemption. You have _____ months left.

BENEFITS ARE NOT TIME LIMITED
FOR PERSONS
WORKING
30 OR MORE HOURS PER WEEK.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

COMPLETING THE AGREEMENT

(Adult included in the grant or Parent counted but not included in the grant)

The social worker and I will work together to consider my goals and identify the steps needed to achieve these goals. We will also identify how the State may be able to help me to reach self-sufficiency.

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State agrees to help me directly, or send me to others who will help me reach the goal of supporting myself.	I will work with my social worker to establish this CMR, take part in the activities listed, and help prove that I am doing what the CMR says I must do.	The State will subtract $50 from my grant if I do not help make this contract with my worker. An extra $50 will be subtracted for each month I do not help to make this contract. **To get benefits back:** I must work with my social worker to develop a Contract of Mutual Responsibility.	This CMR will clearly specify what I need to do to become self-supporting. The CMR will be revised periodically to reflect changes in circumstances and steps throughout the process of becoming self-supporting.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

COMPLETING THE AGREEMENT

(Non-Parent Caretaker or Parent not on the grant)

The social worker and I will work together to consider ways that I can continue to support the child(ren) in my care.

State Responsibilities and Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State will help to provide the required services to the children in my care.	I will work with my social worker to establish this CMR, take part in the activities listed, and help prove that I am doing what the CMR says I must do.	I will lose $50 from my grant if I do not help make this contract with my worker. An extra $50 will be subtracted for each month I do not help to make this contract. **To get benefits back:** I must work with my social worker to develop a Contract of Mutual Responsibility.	This CMR will clearly specify what I need to do to get assistance for the child(ren) in my care. The CMR will be revised periodically to reflect changes in circumstances.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

WORK ASSESSMENT QUESTIONS

(Adult included in the grant or Parent not in the grant)

Highest grade completed in school, or GED _____

What were the last two jobs you held, and when ? _____
_____
_____
_____

What jobs did you hold the longest or like the best? _____
_____
_____

What job skills do you have? _____
_____

What kind of supports do you need to get to work every day (e.g., child care, transportation)?
_____
_____
_____

Do you have a disability that interferes with your ability to find work or stay employed?
[ ] Yes [ ] No

If you have a disability that interferes with your ability to find work or stay employed, do you want to try to work? [ ] Yes [ ] No

Are you a parent caring for a family member in the home who has a disability? [ ] Yes [ ] No

Does the family member with a disability attend school full time? [ ] Yes [ ] No

Are you in a domestic violence situation? [ ]Yes [ ] No

Comments:

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

EMPLOYMENT CONNECTIONS/VOCATIONAL REHABILITATION – JOB READINESS

Employment Connections

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will set up a plan to get me to the point where I can support my family and myself. The State will assist in providing the supports I need to move ahead with the plan. Examples of supports are employment and training programs, and child care. There are special supports for people who have difficulty finding child care.	I agree : • to go to the Employment Connections contractor, • that my attendance and participation in the program will be satisfactory, • that the participation requirement is 30 hours per week unless otherwise indicated in writing. I agree to find child care and notify my worker when I find child care. If I cannot find child care I will call my worker. I agree to report all new income and job information to my worker. I agree to provide all wage verification to my employment contractor as required.	I will not get my first TANF check and my application will be denied if I do not participate for two weeks in a row with my employment and training contractor. My TANF case will be closed for at least one month or until I do what is required, whichever is longer, if I do not continue to participate with employment and training for the required number of hours. **To get benefits back:** I must go to my employment and training contractor and complete at least four weeks in a row of full participation before my benefits can start again.	Successful completion of the items included in the CMR will result in my becoming self-supporting.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

EMPLOYMENT CONNECTIONS/VOCATIONAL REHABILITATION – JOB READINESS

Vocational Rehabilitation for Those Able To Work

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
If I have a disability that is a barrier to employment the State will refer me to the Division of Vocational Rehabilitation (DVR). The Individualized Plan for Employment (IPE) will satisfy part of my Employment and Training requirement. The State will provide me with child care and transportation assistance if it is needed. There are special supports for people who have difficulty finding child care.	I agree: • to apply for DVR services, to cooperate with DVR, and to follow the Individualized Plan for Employment (IPE) • that following the IPE and cooperating with DVR satisfies some of the Employment and Training requirements • to provide a copy of the IPE to DSS. I agree to: • find child care and notify the DSS social worker when I find child care. I will notify the DSS Social worker if I am unable to find child care; • report all new income and job information to my DSS Case Manger • notify my Social worker if my DVR case has been closed.	If I do not cooperate with my employment and training contractor and DVR and follow the IPE my TANF case will close for at least one month or until I cooperate, which ever is longer. **To get benefits back:** I must go to my employment and training contractor and complete four weeks in a row of full participation before my benefits can start again. These activities may include cooperation with DVR.	Successful completion of the items included in the CMR will result in my becoming self-supporting. Successfully completing the IPE will assist me in becoming employed, self sufficient, and independent of the welfare system.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

WORK FOR YOUR WELFARE ACTIVITIES
PART 1 – WORK EXPERIENCE AND COMMUNITY SERVICE

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will find Work For Your Welfare activities for me. I will participate in these activities until I get a job that is at least 30* hours per week. The number of hours I will be required to participate in unpaid work experience or community service will not exceed my grant plus my food stamps, divided by the State minimum wage. The State will provide me with child care assistance if needed. There are special supports for people who have difficulty finding child care.	I agree to go to the Contractor assigned. I agree that my attendance and performance will be satisfactory. I understand that my non-paid work experience and community service combined with other work activity requirements must be at least 30* hours per week. I agree to find child care and notify my worker when I find child care. If I cannot find child care, I will call my worker. I agree to report all new income and job information to my worker.	I understand if I fail to participate in 30* hours of countable and approved activities per week my TANF case will close for at least one month. **To get benefits back:** I must go to the employment and training contractor and complete at least four weeks in a row of full participation before my benefits can start again.	Successful completion of the items included in the CMR will result in my becoming self-supporting.

* Two-parent families: 35 hours; two-parent families with subsidized child care: 55 hours; certain full time students: 20 hours.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

WORK FOR YOUR WELFARE ACTIVITIES
PART 2 – OTHER EMPLOYMENT AND TRAINING ACTVITIES

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will develop with me a plan to get me to the point where I can support my family and myself. The State's Employment and Training contractor(s) will develop with me a weekly schedule of activities which considers my individual needs and abilities.	In addition to working the required number of non-paid work experience and community service hours each week, I will participate in additional hours of employment and training activities. These activities may include but are not limited to: job search activities, job readiness activities, unsubsidized employment, subsidized employment, on-the-job training, vocational education, job skills training, education related to employment, and secondary school or GED program attendance.	I understand if I do not participate in 30* hours of countable and approved activities per week my grant will stop. The grant will not start again for at least one month. **To get benefits back:** I must go to the employment and training contractor and complete at least four weeks in a row of full participation in countable and approved employment and training activities (30* or more hours a week)	Successful completion of the items included in the CMR will result in my becoming self-supporting.

* Two-parent families: 35 hours; two-parent families with subsidized child care: 55 hours; certain full time students: 20 hours.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

STAYING EMPLOYED

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will set up a plan to get me to the point where I can support my family and myself. The State will provide the supports I need to move ahead with the plan, including, but not limited to, employment and training programs and child care assistance. There are special supports for people who have difficulty finding child care.	I understand that if I am working, I am expected to keep my job. I am required to participate in 30* hours of countable and approved employment and training activities per week. Paid employment is one of the approved employment and training activities. I agree to provide all wage verification to my employment contractor as required.	Quitting my job without good cause will result in a loss of my grant for at least one month. **To get benefits back:** I must go to the employment and training contractor and complete at least four weeks in a row of full participation in countable and approved employment and training activities. (30* or more hours a week)	Staying employed will prevent me from having to rely on the State to support me and my family. If I work 30 hours per week, this time will not count towards my lifetime limit for receiving welfare.

* Two-parent families: 35 hours; two-parent families with subsidized child care: 55 hours; certain full time students: 20 hours.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

EDUCATION AND TRAINING (Adults)

State Responsibilities And Supports	My Responsibility	Consequences	Outcomes
The State's Employment and Training contractor(s) will assist me in identifying work activities to ensure that my time in educational activities plus other employment and training activities will equal at least 30* hours per week. The State will provide me with child care and transportation assistance, if needed. There are special supports for people who have difficulty finding child care.	I agree: • that the combination of education/training activities plus work activities will equal 30* hours per week; • to maintain full time student status, passing attendance and grades; • to work with the contractor to get a job during those times when school is not in session; • to show proof of my attendance in school, study activities, and participation. I agree to find child care and notify my worker when I find child care. If I cannot find child care, I will call my worker. I agree to report all new income and job information to my worker.	I understand if I fail to participate in 30* hours of countable and approved activities per week my grant will be stopped. The grant will not start again for at least one month. **To get benefits back:** I must go to the employment and training contractor and complete at least four weeks in a row of full participation in countable and approved employment and training activities. (30* or more hours a week)	Successfully completing the educational or training program in which I am involved will assist me in achieving long-term self-sufficiency and independence from the welfare system.

* Two-parent families: 35 hours; two-parent families with subsidized child care: 55 hours; certain full time students: 20 hours.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

EDUCATION AND TRAINING
VOCATIONAL REHABILITATION

State Responsibilities And Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State will refer me to the Division of Vocational Rehabilitation (DVR) if it is identified that I am unable to work due to a disability but would still like to try to work. The Individualized Plan of Employment (IPE) will satisfy part of my Employment and Training requirement. The State will provide me with child care assistance and transportation assistance if it is needed. There are special supports for people who have difficulty finding child care.	I agree: • to apply for DVR services • to cooperate with DVR and follow the Individualized Plan of Employment (IPE) • to provide a copy of the IPE to my employment and training contractor. I agree to find child care and notify the DSS social worker when I find child care. I will notify the DSS Social worker if I am unable to find child care. I agree to report all new income and job information to my employment and training contractor. I agree to notify my Social worker if my DVR case is closed.	If I do not cooperate with DVR and follow the IPE or cooperate with my employment and training contractor: • the State will remove me from its employment and training rolls • any child care assistance or transportation assistance may stop • I will not lose my cash or food stamp benefits.	Successfully completing the IPE will assist me in becoming employed, self sufficient, and independent of the welfare system.

CASE HEAD NAME :_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

CHILD SUPPORT

Comments:

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will help me to prove paternity, get a support order, enforce it, and collect on the order for the child(ren) in my care.	I agree to cooperate with the Division of Child Support Enforcement, report all new information, and keep all appointments.	My case will be denied or closed if I do not cooperate with the Division of Child Support Enforcement. **To get benefits back:** I must cooperate with the child support requirements.	Cooperation with this requirement will assist me in obtaining long-term cash assistance from the non-custodial parent, which will help me to support the child I have with this person.

CASE HEAD NAME :_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

PARENTING EDUCATION
(*Parents*)

Comments:

State Responsibilities and Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State will identify service providers available in my area that will work with me to support me in my role as a parent to my child(ren). This service will be provided at no cost to me.	I agree to attend parenting education classes by the next case review. I will provide the State with proof that I have enrolled in or completed these classes.	The State will subtract $50 from my grant, and then an extra $50 each month that I do not complete this parenting education requirement. **To get benefits back:** I must show proof that I have enrolled in or completed the parenting program.	As a result of completing this program, I will increase my understanding of ways to cope with the stresses of being a working parent so that these stresses do not affect my being a good parent figure to my child(ren).

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

PARENTING EDUCATION
(Non-Parent Caretakers)

Comments:

State Responsibilities and Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State will identify service providers available in my area that will work with me to support me in my role as a caretaker to my child(ren). This service will be provided at no cost to me.	I agree to attend parenting education classes by the next case review. I will provide the State with proof that I have enrolled in or completed these classes.	The State will subtract $50 from my grant, and then an extra $50 each month that I do not complete this parenting education requirement. **To get benefits back:** I must show proof that I have enrolled in or completed the parenting program.	As a result of completing this program, I will increase my understanding of ways to cope with the unique stresses of being a non-parent caregiver.

CASE HEAD NAME:_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

IMMUNIZATIONS
(Parents or Caretakers)

Comments:

State Responsibilities and Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State will provide an immunization schedule and pay for my child's immunizations through Medicaid.	I agree to make sure that my child's shots are up to date. If they are not up to date, I agree to get them up to date. Child's Name _____ Child's Name _____	The State will subtract $50 from my grant and then an extra $50 for each month I do not meet my immunization responsibilities. **To get benefits back:** I must show proof that I have met my immunization responsibilities.	By meeting these responsibilities, I am protecting my child from common childhood illnesses.

CASE HEAD NAME: _____ DATE _____

PARTICIPANT NAME _____ MCI # _____

SCHOOL ATTENDANCE
FOR
CHILDREN UNDER AGE 16

Comments:

State Responsibilities and Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State provides free public education for all school age children. It also makes other services available to support school attendance, such as school guidance counselors and social workers, Jobs for Delaware Graduates, and services through the Division of Family Services.	I agree that my child will attend school satisfactorily. If my child is not attending school satisfactorily, I agree that I will work with the school to try to help my child to attend satisfactorily.	If I do not work to help my child achieve or maintain satisfactory school attendance, the State will subtract $50 from my grant. I will lose an extra $50 each month until my child attends school satisfactorily. **To get benefits back:** I must show proof that I have cooperated with school officials to have my child achieve or maintain satisfactory school attendance. If I cooperate, I will get my benefits back even if my child does not return to school.	Satisfactory school attendance on my child's part will help him/her to achieve independence and self-sufficiency as an adult.

CASE HEAD NAME :_____ DATE _____

PARTICIPANT NAME _____ MCI # _____

SCHOOL ATTENDANCE
FOR
CHILDREN AGE 16 OR OLDER

Comments:

State Responsibilities and Supports	**My Responsibility**	**Consequences**	**Outcomes**
The State provides free public education for all school age children. It also makes other services available to support school attendance, such as school guidance counselors and social workers, Jobs for Delaware Graduates, and services through the Division of Family Services.	I agree that my child will attend school satisfactorily. If my child is not attending school satisfactorily, I agree that I will work with the school to try to help my child to attend satisfactorily.	If my child does not attend school, he/she will be removed from the grant. **To get benefits back**: I must show proof that my child has returned to school or participated fully in an employment and training activity for four weeks in a row.	Satisfactory school attendance on my child's part will help him/her to achieve independence and self-sufficiency as an adult.

CASE HEAD NAME: _____ DATE _____

PARTICIPANT NAME _____ MCI # _____

FAMILY PLANNING

If a baby is born 10 calendar months or more after I sign the initial contract, the additional child will not be added to my grant.

No cash benefits will be provided for children born to teen parents on or after 1/1/99.

Comments:

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will identify service providers in my area available at no cost to customers.	I agree to obtain family planning information by the next case review for myself and for any of my children that might be sexually active.	The State will subtract $50 from my grant, and then an extra $50 each month that I do not meet my family planning responsibilities. **To get benefits back**: I must show proof that I have obtained family planning information.	By having a family size I can support, I will achieve self sufficiency and independence in less time. I will avoid the many challenges I might face due to the increased demands of a larger family ~~on my time and attention~~.

CASE HEAD NAME _____ DATE _____

PARTICIPANT NAME _____ MCI # _____

SUBSTANCE ABUSE ASSESSMENT

Comments:

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will identify services through the Bridge program and other providers available to customers in my area at no cost.	I agree to attend assessment if referred and, if necessary, treatment.	The State will subtract $50 from my grant, and then an extra $50 each month that I do not meet my substance abuse assessment or treatment responsibilities. **To get benefits back:** I must show proof that I have completed an assessment.	Obtaining treatment for any substance abuse problems I might have will better prepare me for getting and keeping a job.

CASE HEAD NAME _____ DATE _____

PARTICIPANT NAME _____ MCI # _____

SUBSTANCE ABUSE TREATMENT

Comments:

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will identify services through the Bridge program and other providers available to customers in my area at no cost. (Note: If plan calls for Bridge participation and other work activities, both will be completed to satisfy the Employment and Training requirements).	I agree to continue with the current treatment program. I agree to notify my employment and training contractor prior to discontinuing my treatment program.	The State will subtract $50 from my grant, and then an extra $50 each month that I do not meet my substance abuse treatment responsibilities. **To get benefits back:** I must show proof that I am in treatment.	Obtaining treatment for any substance abuse problems I might have will better prepare me for getting and keeping a job.

CASE HEAD NAME: _____ DATE _____

PARTICIPANT NAME _____ MCI # _____

CARING FOR A FAMILY MEMBER WITH A DISABILITY

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
The State will accept a parent caring for a disabled family member who does not attend school full time as satisfying the employment and training requirement. (Other training may be required to fully satisfy the employment and training requirement).	I agree to provide documentation of my family members' disability and the type of care required. I agree to report any changes to my DSS Case Manger that will reduce or eliminate the care that is provided to the family member.	If I am no longer needed to care for a disabled family member I will be required to participate in the employment and training activities determined by the State.	Providing necessary care will reduce the stresses on the family of finding quality, affordable care for my disabled family member. It will also provide a stable, caring environment for the family member.

OTHER

State Responsibilities and Supports	My Responsibility	Consequences	Outcomes
		The State will subtract $50 from my grant, and then an extra $50 each month that I do not meet my responsibilities.	To get benefits back, I must meet my other responsibilities.

Please review and check the boxes below to indicate that you understand the item discussed:

- ☐ I understand that I have the option to participate in adult basic education, secondary education, or vocational training as an approved work activity. I can also participate in post-secondary education up to the first four-year degree.

- ☐ I understand that I must report all changes to my social worker.

- ☐ I understand that the penalty for not participating with Employment and Training is the loss of my cash benefits for at least one month. I understand I must participate with Employment and Training for four weeks in a row before my benefits can start again.

- ☐ I understand that this CMR may be changed by the State, with 30 days written notice, if Federal or State rules change.

- ☐ The signatures below show that the Social Worker and I agree on the activities outlined in this contract. I will participate the required hours with my Employment and Training contractor. I pledge that I will take part fully so long as the State provides me with the supportive services I need. I agree to let the State know if I am having difficulty accessing needed supportive services. I understand that I must fulfill the requirements of the TANF Welfare Reform Program within the time frames specified and that if I do not, all or part of my cash benefits will be lost.

_____

Signature of TANF Participant/Date

_____

Signature of Social Worker/Date

_____

Signature of Translator/Date