SCSEP Community Service  
Assignment Form  

1. Name of participant _____________________  2. PID _____________________  
3. Grantee ____________________________________________  

Host Agency Information  

4. Name of host agency ____________________________________________  
5. Host agency mailing address  
   a. Number and Street, Suite Number; or PO Box  
   b. City  
   c. State  
   d. ZIP code  
6. FEIN ________________________________  
7. Host agency type:  □ Not-for-profit  □ Government  
7a. Date of host agency agreement __________________________ (MM/DD/YYYY)  
7b. Date of host agency monitoring visit __________________________ (MM/DD/YYYY)  
8. Host agency site name and location ____________________________________________  
8a. Host agency job codes:  i ________        ii ________        iii ________  

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Community and Social Services</td>
<td>10. Legal</td>
<td>17. Retail, Sales, and Related</td>
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<td>7. Farming, Fishing, and Forestry</td>
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</table>

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average six minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Investment, Room C-4510, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).  

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(Rev. 12/10/2018)
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8b. Host agency continued availability □ Available □ Not available

Contact/Supervisor Information

9. Name of contact person ____________________________________________

10. Contact person’s mailing address if different from number 5

   a. Organization
   ________________________________________________________________

   b. Number and Street, Suite Number; or PO Box
   ________________________________________________________________

   c. City
   ________________________________________________________________

   d. State  e. ZIP Code

11. Contact person’s title ____________________________________________

11a. Contact person’s salutation □ Mr. □ Ms. □ Dr.

12. Contact person’s phone number _________________________________

12a. Contact person’s fax number _________________________________

12a1. Contact person’s cell phone number ________________________________

12b. Contact person’s e-mail address ________________________________

Complete fields 12c-12i if supervisor is different from contact person (number 9). If
supervisor is the same as contact person, skip to field 12j.

12c. Name of supervisor ____________________________________________

12d. Supervisor’s mailing address if different from number 5

   a. Organization
   ________________________________________________________________

   b. Number and Street, Suite Number; or PO Box
   ________________________________________________________________

   c. City
   ________________________________________________________________

   d. State  e. ZIP Code

12e. Supervisor’s title ____________________________________________

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12f. Supervisor’s salutation  [ ] Mr.  [ ] Ms.  [ ] Dr.

12g. Supervisor’s phone number

12h. Supervisor’s fax number

12h1. Supervisor’s cell phone number

12i. Supervisor’s e-mail address

12j. Funding source of supervisor or contact person/supervisor:
   [ ] Federal  [ ] Non-federal $_______ (hourly rate) _______ (average hours per week)

Assignment Information

13. Assignment date______________________________ (MM/DD/YYYY)

14. Start assignment date_________________________ (MM/DD/YYYY)

15. End date______________________________ (MM/DD/YYYY)

15a. Approved break in participation
Start date _______ (MM/DD/YYYY)  Expected end date________ (MM/DD/YYYY)
Actual end date__________ (MM/DD/YYYY)

15b. Reason for approved break in participation
   [ ] i. Family/health          [ ] iii. Administrative
   [ ] ii. Personal             [ ] iv. Other (specify)________________

15c. Comments on approved break in participation

16. Participant assigned to:
   [ ] i. Grantee or sub-recipient/local project
   [ ] ii. Workforce partner
   [ ] iii. Other host agency

16a. If participant assigned to i or ii:
   1. CSA wage (per hour) $________________
   2. Number of hours per week assigned ____________

16b. Participant’s schedule


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16c. Date of safety consultation with participant ________________ (MM/DD/YYYY)

17. Community service assignment code ________________ (Select only one code from following lists)

Service to the general community includes the following activities:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1.</td>
<td>Education</td>
</tr>
<tr>
<td>G2.</td>
<td>Health and Hospitals</td>
</tr>
<tr>
<td>G3.</td>
<td>Housing and Home Rehabilitation</td>
</tr>
<tr>
<td>G4.</td>
<td>Employment Assistance</td>
</tr>
<tr>
<td>G5.</td>
<td>Recreation, Parks, and Forests</td>
</tr>
<tr>
<td>G6.</td>
<td>Environmental Quality</td>
</tr>
<tr>
<td>G7.</td>
<td>Public Works &amp; Transportation</td>
</tr>
<tr>
<td>G8.</td>
<td>Social Services</td>
</tr>
<tr>
<td>G9.</td>
<td>Legal</td>
</tr>
<tr>
<td>G10.</td>
<td>Financial</td>
</tr>
<tr>
<td>G11.</td>
<td>Counseling</td>
</tr>
<tr>
<td>G12.</td>
<td>Conservation</td>
</tr>
<tr>
<td>G13.</td>
<td>Community Betterment</td>
</tr>
<tr>
<td>G14.</td>
<td>Other</td>
</tr>
</tbody>
</table>

Service to the elderly community includes the following activities:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1.</td>
<td>Project Administration</td>
</tr>
<tr>
<td>E2.</td>
<td>Health and Home Care</td>
</tr>
<tr>
<td>E3.</td>
<td>Housing and Home Rehabilitation</td>
</tr>
<tr>
<td>E4.</td>
<td>Employment Assistance</td>
</tr>
<tr>
<td>E5.</td>
<td>Recreation/Senior Centers</td>
</tr>
<tr>
<td>E6.</td>
<td>Nutrition Programs</td>
</tr>
<tr>
<td>E7.</td>
<td>Transportation</td>
</tr>
<tr>
<td>E8.</td>
<td>Outreach/Referral</td>
</tr>
<tr>
<td>E9.</td>
<td>Legal</td>
</tr>
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<td>E10.</td>
<td>Financial</td>
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<td>Counseling</td>
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<td>E13.</td>
<td>Community Betterment</td>
</tr>
<tr>
<td>E14.</td>
<td>Other</td>
</tr>
</tbody>
</table>

18. Community service assignment title ____________________________________________

18a. Participant’s job code

<table>
<thead>
<tr>
<th>Code Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3. Community and Social Services</td>
<td>10. Legal</td>
</tr>
<tr>
<td>7. Farming, Fishing, and Forestry</td>
<td>14. Personal Care and Service</td>
</tr>
<tr>
<td>15. Production, Assembly, Light Industrial</td>
<td>16. Protective Service</td>
</tr>
<tr>
<td>17. Retail, Sales, and Related</td>
<td>18. Self-Employment</td>
</tr>
</tbody>
</table>

18b. Participant’s workers’ compensation code ________________

19. Total hours paid in quarter

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

20. Types of training received (Check all that apply)

- [ ] a. General training (basic skills)
- [ ] b. Specialized training (specific job/industry)
- [ ] c. On-the-job experience (OJE)
- [ ] d. Other (specify) ________________
- [ ] e. None
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20a.1. Type of supportive service provided:
- [ ] i. Dependent care (child or adult)
- [ ] ii. Health and medical services
- [ ] iii. Housing, including temporary shelter
- [ ] iv. Incidentals such as work shoes, badges, uniforms, eyeglasses, and tools
- [ ] v. Needs-related payments, such as utilities or food
- [ ] vi. Special job-related or personal counseling
- [ ] vii. Transportation
- [ ] viii. Other (specify)

20a.2. Date supportive service provided________________________ (MM/DD/YYYY)

20a.3. Supportive service provided by:
- [ ] i. Grantee or sub-recipient/local project
- [ ] ii. Workforce partner
- [ ] iii. Both i and ii
- [ ] iv. Other (specify)

21. Total hours of paid training received in quarter
- Quarter 1 ________________  Quarter 3 ________________
- Quarter 2 ________________  Quarter 4 ________________

22. Community service assignment comments
Sub-Grantee Provided Training Information

### Training Provider Information

23. Name of training provider or OJE employer ____________________________

24. Training provider or OJE employer mailing address

   a. Number and Street, Suite Number; or PO Box __________________________

   b. City ____________________________________________

   c. State ______________________________________________________________________

   d. ZIP code

25. Training provider continued availability

   - Available
   - Not available

### Contact Person Information

26. Name of training provider or OJE employer contact person ____________________________

27. Contact person’s mailing address if different from number 24

   a. Organization ______________________________________________________________________

   b. Number and Street, Suite Number; or PO Box __________________________

   c. City ____________________________________________

   d. State ______________________________________________________________________

   e. ZIP Code

28. Contact person’s title ____________________________________________

29. Contact person’s salutation

   - Mr.
   - Ms.
   - Dr.

30. Contact person’s phone number ____________________________________________

31. Contact person’s fax number ____________________________________________

31a. Contact person’s cell phone number ____________________________________________

32. Contact person’s e-mail ____________________________________________
### Training Information

33. Types of training received (Check only one per training record)

- a. General training (basic skills)
- b. Specialized training (specific job/industry)
- c. On-the-job experience (OJE)
- d. Other (specify)_________________

34. Job code for which training is provided, if relevant __________

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35. Participant’s workers’ compensation code in training __________

36. Start training date __________________________ (MM/DD/YYYY)

37. End training date ____________________________ (MM/DD/YYYY)

38. Average number of hours of training per week________

39. Average number of hours of community service per week during training________

40. If OJE, wages paid by:

- ☐ Sub-grantee
- ☐ Employer and reimbursed by sub-grantee at rate of _____%

41. Training wage (per hour) $ ____________________

42. Total wages paid to participant or reimbursed to employer $ ____________________

43. Total amount paid to training provider for provision of training (other than reimbursement to employer) $ ____________________

44. Training Comments