



No More Empty Pots Application Culinary Workforce Training Program

Thank you for your interest in the No More Empty Pots Culinary Workforce Training Program! If you have any questions or concerns as you complete this application, do not hesitate to contact program staff at 402-979-5478 or cwtp@nmepomaha.org.

All applicants must meet below requirements to be considered for No More Empty Pots Culinary Workforce Training Program:

Eligibility Requirements:

- Must be 16 years of age or older
- Arrangements for necessary accommodations must be made prior to orientation
- Legally entitled to work in the U.S.
- Willing to commit to all program components
- Have a strong interest in a culinary career
- Able to commit to 15 weeks of unpaid programming from 9 AM – 4 PM, Monday - Friday

Legal Restrictions:

- No outstanding warrants, holds, detainers or out-of-state pending charges
- No conviction of Special Victims Crimes such as sexual assault, child abuse
- No history of capital crimes such as domestic assault crimes or crimes against children
- No escape convictions
- Reside in the Omaha Metropolitan area

Section 1: Personal Information

Full Legal Name: _____ SSN: _____ - _____ - _____

First Name

Middle Initial

Last Name

Preferred name(s): _____ Age: _____ Date of Birth: ____/____/____

Home Address: _____

Street Address

City/State

Zip Code

Mailing Address: _____

Street Address/PO Box

City/State

Zip Code

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Put a star* next to the best way to contact you.

Emergency Contact:

Name: _____ Relationship to you: _____

Phone: _____ Alternate Phone: _____

Are you a U.S. citizen? **Yes / No** If no, are you legally entitled to work in the U.S.? **Yes / No**

Are you a Nebraska resident? **Yes / No**

Are you now serving or have you ever served in the armed forces (veteran)? **Yes / No**

Are you currently or formerly a ward of the state? **Yes / No** If yes: age(s): _____

How would you like us to report your sex/gender? (circle) **M / F / T** Self Identify: _____

If you would like NMEP staff to know, you can report your gender pronouns here (circle):

she/her he/his they/their self identify: _____

Race/Ethnicity (check all that apply or self-identify):

- American Indian/Alaska Native
- Asian
- Black/African American
- Hispanic/Latinx
- Native Hawaiian/Pacific Islander
- White/European American
- Self Identify: _____

Section 2: Uniform Sizing

You will be issued your own pair of shoes and a clean uniform every day. Please circle or list your sizes:

Shoe: **Men** **Women** **Shoe size:** _____

Jacket: **XS** **S** **M** **L** **XL** **2XL** **3XL** **4XL**

Pant: **XS** **S** **M** **L** **XL** **2XL** **3XL** **4XL**

Uniform specifications? For example wide shoes, long pants, etc.:

Section 3: Educational History (will not qualify/disqualify you for services)

Highest grade level completed? (Not a criterion for admission): _____

Please list the schools you have attended:

High School (include city and state):	Diploma / GED:	Dates:
Vocational Program:	Certificate:	Dates:
College:	Degree/Major:	Dates:

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Section 4: Employment History (will not qualify/disqualify you for services)

Start with the most recent job or volunteer experience and list backward.

Name of Employer:			
City, State, Zip:	Supervisor's Name:	Employment Dates	Pay or Salary
	Phone Number:	From: To:	Start: Final:
Last Job Title:			
Duties Performed:			
Skills Used and Learned:			
Promotions or Advancements:			
Reason for Leaving:			

Name of Employer:			
City, State, Zip:	Supervisor's Name:	Employment Dates	Pay or Salary
	Phone Number:	From: To:	Start: Final:
Last Job Title:			
Duties Performed:			
Skills Used and Learned:			
Promotions or Advancements:			
Reason for Leaving:			

Name of Employer:			
City, State, Zip:	Supervisor's Name:	Employment Dates	Pay or Salary
	Phone Number:	From:	Start:

		To:	Final:
Last Job Title:			
Duties Performed:			
Skills Used and Learned:			
Promotions or Advancements:			
Reason for Leaving:			

Please give details of any food service experience you have had, including duties and number of years:

Section 5: Housing (will not qualify/disqualify you for services)

1. What is your current housing situation? _____

Will you be moving or losing your current housing situation during the program? **Yes / No**

If yes, what is your housing plan? _____

Have you ever experienced homelessness? **Yes / No** If yes, dates: _____

Section 6: Transportation (will not qualify/disqualify you for services)

1. Do you have a driver's license? **Y / N** If no, are you eligible for one? **Y / N**

2. What is your primary source of transportation? _____

3. Transportation plan during the program? _____

Section 7: Caregiving Responsibilities (will not qualify/disqualify you for services)

Do you have children? **Yes / No** Any children under 18 in your custody? **Yes / No**

If you have children under 18 in your custody, what is your childcare plan?

Do you have caregiving responsibility for other family members/friends (for example an aging parent or a neighbor with a disability)? **Yes / No** If yes, describe: _____

Section 8: Income (will not qualify/disqualify you for services)

Annual household income: _____

Do you have any of the following sources of income or a pending application?

Type:	Check if Receiving:	Amount:	Duration/Reason:
SSI			
SSDI			
Veterans Benefits			
Food Stamps			
TANF			
Child Support			
Wages			
Unemployment			
Other Income			

Notes about the above applications/services: _____

Section 9: Accessibility

What accommodations do you need for the program to be accessible? (Examples could include shoes with extra padding, knives with padded grips, time for breaks to take medication or perform doctor-ordered exercises, written materials provided in another language, etc.)

Section 10: Health Insurance (will not qualify/disqualify you for services. We will make a referral for a mental health screening using this insurance information. If you do not have coverage we will cover the cost of your biopsychosocial assessment.)

- Uninsured
- Medicaid *Circle Medicaid Provider:* NE Totalcare United Health WellCare
 Medicaid #: _____ Totalcare/UHC/WellCare #: _____
- Medicare Insurance/Medicare #: _____
 Policy ID #: _____ Group #: _____
- Veterans Health Insurance
- Private Insurance Private insurance provider name: _____
 Insurance #: _____ Policy ID #: _____
 Group #: _____ Co-pay amount: _____
 Deductible Amount: _____

Insured Address (if different): _____

Section 11: Health (will not qualify/disqualify you for services)

List ALL medications you are currently taking. Please also list past and current health and mental health diagnoses, including ones that aren't current.

Condition/Diagnosis:	Medication or Treatment plan:	Provider Who Diagnosed/Prescribed:	Date Diagnosed/Prescribed:

Side effects of medications: _____

Primary medical care provider: _____

Name of provider/clinic

Address

Phone

Date of your last visit to your primary medical care provider? ___/___/___

Primary mental health care provider: _____

Name of provider/clinic

Address

Phone

Date of last visit to mental health care provider: ___/___/___

Date of last dental visit? ___/___/___ Date of last eye exam? ___/___/___

Prescribed vision correction (glasses)? **Y / N** Able to lift 50 pounds or more? **Y / N**

When was your last TB/PPD test? ___/___/___ Circle was it: **Negative / Positive**

List dietary restrictions, allergies, and severity. (For example, if you're allergic to shellfish, are you able to touch it but not eat it? Include eating practices due to religious or health reasons.)

Have you ever been hospitalized due to mental health concerns? **Y / N**

If yes, dates and reason?: _____

Did/does anyone in your family have a problem with alcohol, drugs, abuse, violent behavior, mental illness, or anything else you would consider a problem? (In other words, have you experienced trauma) **Y / N**

If yes, what do you need NMEP staff to know? What do you need from us? (We will follow up during the interview):

Section 12: Substance Use History (Drugs/alcohol)

1. Do you identify as a social drinker? **Y / N**
2. Do you have a history of substance (drug/alcohol) abuse? **Y / N**

If NO, continue to section 13.

3. Have you been clean and sober for 120 days? **Y / N**

Type of Substance	Frequency Used	Quantity Used	Date of Last Use

4. Have you EVER been in a drug and/or alcohol treatment program? **Y / N**

5. If yes, please complete the following chart:

Program:	Inpatient, Outpatient, or Residential:	Dates:	Completed (Yes/ No):

6. What are you doing to maintain your sobriety? _____

7. Do you attend meetings? **Y / N**
8. Do you have a sponsor? **Y / N**

Section 13: Legal History

Legal Restrictions:

- No outstanding warrants, holds, detainers or out-of-state pending charges
- No conviction of Special Victims Crimes such as sexual assault, child abuse
- No history of capital crimes such as domestic assault crimes or crimes against children
- No escape convictions

Do you have any of the above legal issues? **Yes / No** If yes, please describe:

Ever incarcerated 30 days or more? **Yes / No**

Upcoming court dates or other current legal obligations: _____

Have you EVER been convicted of a misdemeanor? **Yes / No**

If yes, list charge(s): _____

Incarcerated? **Yes / No** If yes, dates served: _____

Explanation of charge or situation: _____

Have you EVER been convicted of a felony? **Yes / No**

If yes, name(s) of charge(s): _____

Incarcerated? **Yes / No** If yes, dates served: _____

Explanation of charge or situation: _____

Please circle if you are on: **Probation Parole Work release**

If yes, date range: ___/___/___ - ___/___/___

Reporting officer name, title: _____

Phone _____ Email: _____

How often/when you report: _____

Section 14: Other Services and Caseworkers

Please be as comprehensive as possible. This is the professional support system that will aid you during the program.

Contact Name, Title: _____

Agency or Program: _____

Phone: _____ Email: _____

Services provided: _____

Programmatic requirements: _____

Contact Name, Title: _____

Agency or Program: _____

Phone: _____ Email: _____

Services provided: _____

Programmatic requirements: _____

Contact Name, Title: _____

Agency or Program: _____

Phone: _____ Email: _____

Services provided: _____

Programmatic requirements: _____

Section 15: Short Answer

1. What are your personal strengths? What skills would you bring to the training program?

2. What have been the main challenges and/or barriers in your life recently and how have you dealt with them?

3. How do you deal with stressful situations? What is your strategy to calm down if you get into an argument with a coworker/friend/family member etc.?

4. Who do you see as your support network?

5. Why are you applying for the No More Empty Pots Culinary Workforce Training Program?

6. What are your career goals?

Section 19: Explanation of Confidentiality and Use of Personal Information

Keeping your personal information private is No More Empty Pots' highest priority. The program coordinator and case managers have primary access to your records. Limited information will be shared with other No More Empty Pots staff, for example, providing your uniform sizes to the Lead Chef Instructor, who orders the uniforms. We will also provide limited information to the organizations with whom we partner to provide program services. By participating in this program, you are permitting No More Empty Pots to release your personal information to these partners on a need to know basis. These organizations include:

- Center for Holistic Development (referral for your biopsychosocial assessment)
- Mindfulness Outreach Initiative (name)
- Douglas County Extension Services (name, to register you for ServSafe and nutrition education)
- Heartland Workforce Solutions' WorkOpps program (name, to support your enrollment in WorkOpps)

Section 16: Program Requirements

Listed below are the requirements for the No More Empty Pots Culinary Workforce Training Program. Please initial after each if you agree:

- I commit to daily attendance from 9 AM to 4 PM for the 15 weeks _____
- I understand that I will **not** be paid during the program _____
- If I am accepted I agree to be interviewed by a mental health professional who will work with me to create a personal development plan _____
- I agree to engage in the activities of my development plan _____
- I am willing to accept instruction from my instructors and supervisors and complete the work that is assigned to me with a positive attitude _____
- I am willing to confront my personal challenges and/or barriers _____
- I understand that No More Empty Pots is not responsible for damage, loss, or theft of my personal property _____
- I understand that limited personal information about me will be shared among No More Empty Pots staff and program partner organizations in order to deliver the program _____

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without previous notice. I hereby give No More Empty Pots Culinary Workforce Training Program permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release No More Empty Pots Culinary Workforce Training Program from any liability as a result of such contract.

Applicant Signature

____ / ____ / ____
Date

Referrer Signature

____ / ____ / ____
Date

20. Authorization of Release of Information

In order to provide individualized support to students, the Culinary Workforce Training Program requests permission to exchange information about you with other professionals you work with. For example, you could permit your case manager for ResCare TANF/ADC to exchange information with the program in order to support your success. Authorizing No More Empty Pots to release your information to other agencies and other agencies to release your information to No More Empty Pots is completely your choice. You can also change your mind. If at a later date you no longer want information shared with a person or an agency listed below, notify your CWTP case manager and we will amend the Release of Information record. This release of information will expire 1 year after the undersigned date.

I, the undersigned, authorize No More Empty Pots to release my information, at NMEP staff's discretion, to the following agencies, caseworkers, or individuals, and for these parties to release information about me to No More Empty Pots:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Applicant Signature

____ / ____ / ____
Date

Referrer Signature

____ / ____ / ____
Date

Date of ROI Expiration: ____ / ____ / ____