Attachment B: WIOA Title I Self-Attestation Form Medical Information

This document must be stored in a separate location.

Applicant Information:

Last Name:	**First Name:**	**VaWC#** *(or last 4 of SSN)*	**Date:**

Address:	**City:**	**State:**	**Zip:**

Individuals entering WIOA services may self-attest to the information below:

1.	I attest that I have disability as defined in Section 3(2)(a) of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102). Under that definition, a "disability" is a physical or mental impairment that substantially limits one or more of the person's major life activities.	Yes ☐	No ☐
2.	I attest I am pregnant. A pregnant individual can only be the expectant mother. (Youth Program Eligibility Only).	Yes ☐	No ☐

Self-Attestation Statement:

I certify that the information provided on this document is true and accurate to the best of my knowledge and belief. I understand that the above information, if misrepresented or incomplete, may be grounds for immediate termination from any WIOA program and/or penalties as specified by law.

SIGNATURE OF PARTICIPANT (or legal guardian if under the age of 18) **DATE**

X

Staff Verification Statement:

I certify that the individual whose signature appears above provided the information recorded on this form. I certify that I attempted to obtain other source documentation to verify eligibility. Self-attestation is being used so as not to delay or prevent enrollment and receipt of services in a program.

SIGNATURE OF STAFF **DATE**

X