New Hampshire Employment Security

Pathway to Work

REQUEST TO RECEIVE UNEMPLOYMENT BENEFITS AND WORK SEARCH
WAIVER WHILE IN A PATHWAY TO WORK SELF EMPLOYMENT ASSISTANCE PROGRAM

Name: ___________________________________________ SS #: ______________________________

The following information is needed to determine if it is appropriate to waive the requirements in RSA 282A:31, 1(c) which provides that an individual shall be eligible to receive benefits with respect to any week only if he/she is ready, willing and able to accept and perform suitable work on all the shifts and during all the hours for which there is a market for the services he/she offers and that he/she has made an effort to find employment, while he/she is in training. (If these requirements are waived, it DOES NOT excuse you from meeting the requirement of EMP 403.06 which states that an individual who has established a benefit year must first earn an additional $700 of wages “in employment” to be eligible for benefits in the individual’s next benefit year.)

PLEASE ANSWER ALL QUESTIONS, GIVING A COMPLETE, DETAILED STATEMENT

I. 1. TRAINING INSTITUTION: __________________________ LOCATION: __________________________

   Name            City/Town  State  Zip Code

2. NAME OF TRAINING COURSE OR PROGRAM: ________________________________________________

   * LENGTH OF TRAINING PROGRAM: ________________________________________________

   * START DATE: _____/_____/____  END DATE: _____/_____/____

3. FUNDING SOURCE FOR TRAINING (WIA TITLE I, PELL GRANT, TRADE ACT, SELF, OTHER) circle one

4. SKILLS YOU WILL GAIN:

5. ACTIVITY RESOURCE/PROVIDER: __________________________ LOCATION: __________________________

   Name            City/Town  State  Zip Code

6. NAME OF ACTIVITY: __________________________ LENGTH OF ACTIVITY: __________________________

   START DATE: _____/_____/____  END DATE: _____/_____/____

   NUMBER OF HOURS PER WEEK: ______________

7. NAME OF ACTIVITY: __________________________ LENGTH OF ACTIVITY: __________________________

   START DATE: _____/_____/____  END DATE: _____/_____/____

   NUMBER OF HOURS PER WEEK: ______________

   (If additional activities, attach information for all activities participating in)

Continued on Reverse Side

NHES is a proud member of America’s Workforce Network and NH Works. NHES is an Equal Opportunity Employer and complies with the Americans with Disabilities Act. Auxiliary Aids and Services are available on request of individuals with disabilities.

Telephone (603) 224-3311  Fax (603) 228-4145  TDD/TTY Access: Relay 1-800-735-2964  Web site: www.nhes.nh.gov

NHES 0403
N-7/13
INITIAL UI DATE: _____/_____/_____

BYE: _____________

WBA: _____________

WBA BALANCE: _____________

NUMBER OF WEEKS REMAINING: _____________

PTW APPLICATION DATE: _____________

CHECKLIST

ATTACHMENTS:

-------------- List of courses to be taken
-------------- List of self employment assistance activities
-------------- Application
-------------- Overview of business idea
-------------- Review of Demand Occupation, Growth Occupation, Licensing Requirements

REferred TO:

-------------- Workforce Investment Act Representative
-------------- Small Business Development Center (SBDC)
-------------- Community College System of NH
-------------- Other Training Provider: _____________________________________________________

LABOR MARKET INFORMATION REVIEW

-------------- Demand Occupation Recommend Not Recommend Initials _____
-------------- Growth Occupation Recommend Not Recommend Initials _____
-------------- Occupational Licensing Requirements Yes No

Comments:__________________________________________________________________________________
___________________________________________________________________________________________

-------------- Claimant was informed a written determination regarding this request will be made and was advised of appeal rights
-------------- Claimant was informed the duration of benefits is not affected by length of training/activities
-------------- Claimant has been instructed of the requirements to file their weekly Continued Claim Form by paper form, timely and answer all questions pertaining to the plan

-------------- Follow up date: _____/_____/_____ Time: _____________
-------------- SBDC recommend for approval ____________ Not recommended for SBDC approval
-------------- NHES recommend for approval
-------------- Not recommended for approval. Fails to meet this/these conditions:_______________________

I understand and agree to the requirements that include willingness to engage in full time (37.5) hours per weeks of activities for the Pathway To Work Program.

Claimant Signature: ________________________________________  Date:  _____/______/_____

A copy of this completed form was provided to the claimant. The original and attachments have been forwarded to Operations.

Staff Signature: ________________________________________  Date:  _____/______/_____