

Contract No. 12 – H135
California Work Opportunity and Responsibility to Kids (CalWORKs)
Greater Avenues for Independence (GAIN)
Work Experience/Work Study/Community Service Combined Agreement

32726

This Subcontract Agreement is entered into this 1st day of **January 2012** between the City of Hawthorne by its Job Training & Development Department, on behalf of the South Bay Workforce Investment Board, hereinafter referred to as INTERMEDIARY CONTRACTOR, and **City of Long Beach**:

This contract is a subcontract under the terms of a prime contract, No. COH07001 with the County of Los Angeles, hereinafter referred to as COUNTY. All representations and warranties expressed herein shall inure to the benefit of the COUNTY. The contract is non-financial.

Non-financial agreements connote that there shall be no cost to the INTERMEDIARY CONTRACTOR or the COUNTY for services provided by the SUBCONTRACTOR. All representations and warranties expressed herein shall inure to the benefit of the COUNTY.

In providing activities for the CalWORKs/GAIN Program hereunder, SUBCONTRACTOR shall conform to the provisions set forth in this subcontract agreement, including any and all Exhibits hereto and all current and future CalWORKs/GAIN directives. INTERMEDIARY CONTRACTOR will notify SUBCONTRACTOR of any CalWORKs/GAIN directives in writing upon receiving said CalWORKs/GAIN directives from the COUNTY. This shall be done in order to maintain the various programs integrity and avoid any conflict of interest in its administration.

For this agreement, if applicable, Work Experience (WEX) shall be defined as a salaried or non-salaried work assignment with a public, private for-profit or private non-profit organization that supplies a given participant with work behavior skills and a reference for future unsubsidized employment or on-the-job enhancement of existing or recently acquired work skills.

For this agreement, if applicable, Work Study (WS) shall be defined as an academic program that enables college students to gain work experience while continuing their studies. The employment is temporary and the worksite is not expected to retain the participant beyond the work assignment.

For this agreement, if applicable, Community Service (CS) is a non-salaried activity performed by the eligible participants in the public or private non-profit sector under the close supervision of a community service provider. Community Service activities are intended to provide participants with necessary job skills that can lead to full-time unsubsidized employment and self-sufficiency.

I. GENERAL PROVISIONS

A. STATEMENT OF WORK

SUBCONTRACTOR agrees to perform the duties and activities contained in the Work Experience/Work Study Statement of Work, which is attached hereto, respectively labeled EXHIBIT 1, and is incorporated herein by reference, as if set forth in full.

B. TERM OF AGREEMENT

The term of this agreement shall be effective from the date of its execution through March 31, 2012. In the event of the extension of funding from the Los Angeles County Department of Public Social Services for the Work Experience/Workstudy/Community Service programs under the Transitional Subsidized Employment Program, the term of this agreement shall be automatically extended until March 31, 2015. Both parties shall perform and complete services for those activities covered by this subcontract until this subcontract expires or is terminated in writing by either party.

C. CHANGES AND AMENDMENTS OF TERMS

This Agreement may be amended upon mutual written consent of both parties.

D. NOTICE

Any notice or notices required pursuant to this subcontract may be personally served on the other party, or may be served by certified mail, postage prepaid or return receipt request. All notices required to be given to the INTERMEDIARY CONTRACTOR shall be delivered or mailed to the parties as follows:

**Mr. Jan Vogel, Executive Director
South Bay Workforce Investment Board
11539 Hawthorne Boulevard, 5th Floor
Hawthorne, CA 90250
310.970.7700**

All notices required to be given to the SUBCONTRACTOR shall be delivered or mailed to the address below:

**Melu Habacon
City of Long Beach
333 W. Ocean Blvd.
Long Beach, CA 90802
562-570-3744**

Either party may designate a new address by giving written notice to the other party.

E. SUBCONTRACTOR CONFIDENTIALITY AGREEMENT

Employees of SUBCONTRACTOR who have access to participant files and/or information must complete, sign, and adhere to the "SUBCONTRACTOR EMPLOYEE ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT," attached hereto as EXHIBIT 2, which is incorporated herein by reference, as if set forth in full. Subcontractor will identify specific staff who will have access to participant files. A copy of this form must be on file prior to a worksite employee commencing any work under to this agreement.

F. SUBCONTRACTING

No part of the SUBCONTRACTOR'S service obligations may be further subcontracted to any person or entity without the express written consent of the INTERMEDIARY CONTRACTOR and the COUNTY.

G. SUBCONTRACTOR RATING

SUBCONTRACTOR shall complete and return to INTERMEDIARY CONTRACTOR, the Los Angeles County Department of Public Social Services "Agency Rating System Sheet" attached hereto as EXHIBIT 3, which is incorporated herein, as if set forth in full. Said rating system sheet will be used by INTERMEDIARY CONTRACTOR, COUNTY, and participants to evaluate the employment development services offered by SUBCONTRACTOR under this agreement.

H. INSURANCE

SUBCONTRACTOR agrees to maintain in force at all times Comprehensive General Liability Insurance that willfully protect the SUBCONTRACTOR, INTERMEDIARY CONTRACTOR AND COUNTY from claims arising out of any act or employer's liability laws. Policies shall stipulate that the INTERMEDIARY CONTRACTOR, its employees, officers and agents and COUNTY, its Special

Districts, its officials, officers and employees be named as additional insured and that INTERMEDIARY CONTRACTOR be given 30 days written notice of any modification or cancellations of insurance by the carrier. SUBCONTRACTOR, prior to the commencement of a subcontract with INTERMEDIARY CONTRACTOR, shall deliver to INTERMEDIARY CONTRACTOR a current certificate evidencing the required insurance coverages, secured through carriers reasonably satisfactory to the INTERMEDIARY CONTRACTOR. SUBCONTRACTOR shall maintain coverages and limits as follows:

1. General Liability

SUBCONTRACTOR is required to maintain a general liability insurance policy (written on ISO policy form CG 00 01 or its equivalent) with limits of not less than the following:

General Aggregate:	\$2 million
Products /Completed Operations Aggregate:	\$1 million
Personal and Advertising Injury	\$1 million
Each Occurrence:	\$1 million

2. Automobile Liability

If a SUBCONTRACTOR, in conducting activities under this Agreement, uses motor vehicles, the SUBCONTRACTOR is required to maintain an automobile insurance policy (written on ISO policy form CA 00 01 or its equivalent) with a limit of liability of not less than \$1 million for each accident. Such insurance shall include coverage for all "owned", "hired" and "non-owned" vehicles, or coverage for "any auto." Should SUBCONTRACTOR and its employees not use any motor vehicles to provide the services required under this agreement, SUBCONTRACTOR shall furnish to INTERMEDIARY CONTRACTOR, on SUBCONTRACTOR's letterhead, a letter stating "Company owned or operated vehicles will not be used to perform any of the services contemplated by the agreement between SUBCONTRACTOR and the City of Hawthorne."

3. Workers Compensation and Employers' Liability

SUBCONTRACTOR is required to maintain and provide evidence of insurance providing workers compensation benefits for subcontractor's employees, as required by the Labor Code

of the State of California or by any other state, and for which sub-contractor is responsible. Such insurance also shall include Employers' Liability coverage with limits of not less than the following:

Each Accident:	\$1 million
Disease - policy limit:	\$1 million
Disease - each employee:	\$1 million

SUBCONTRACTOR shall not be responsible to provide workers compensation benefits for participants under this subcontract agreement. The parties hereto further agree and recognize that the participants assigned to Subcontractor's worksites are not employees of SUBCONTRACTOR and are not entitled to any benefits to which SUBCONTRACTOR's employees are entitled, including, but not limited to, unemployment insurance, state disability, or health insurance.

I. PUBLIC ENTITY EVIDENCE OF INSURANCE

Subject to review and approval by INTERMEDIARY CONTRACTOR'S counsel, INTERMEDIARY CONTRACTOR will accept from public entity subcontractors evidence of an on-going self-insurance program as an equivalent for such coverage as described above in Section H, parts 1, 2, and 3. (General Liability and Automobile Coverage Limits).

J. RELIGIOUS ACTIVITIES PROHIBITED

SUBCONTRACTOR agrees that no participant shall be asked or required to participate in the promotion of religious activities. Furthermore, SUBCONTRACTOR agrees that it will not perform, nor permit to be performed, any religious activities in connection with the performance of this subcontract agreement.

K. POLITICAL ACTIVITIES PROHIBITED

No participant shall be asked or required to participate in any political activity of any kind. Participants shall not be asked or required to participate in any manner in any partisan political activity, or activity for or against the election of candidates for office.

L. REPORTING WELFARE FRAUD, ELDER ABUSE AND CHILD ABUSE

SUBCONTRACTOR shall report all suspected or actual welfare fraud, elder abuse and child abuse discovered by SUBCONTRACTOR. Welfare fraud is specified in the State Operations Manual, Section 20000, elder abuse is specified in DPSS Administrative Directive 2898, and child abuse is specified in Penal Code 11166 and 11167. Reports shall be made by telephone call as required by the referenced regulations and followed up in writing to the GAIN Services Worker (GSW) within three (3) workdays after discovery.

II. COMPLIANCE WITH THE LAW

A. CIVIL RIGHTS

SUBCONTRACTOR shall ensure that services and benefits are provided without regard to race, color, religion, sex, age or national origin, political affiliation, marital status or disability in accordance with Title VI of the Civil Rights Act of 1964, and California Government Code, Section 11135. SUBCONTRACTOR shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified disabled persons under any program or activity which receives or benefits from Federal or State financial assistance. SUBCONTRACTOR shall comply with provisions of Titles VI and VII of the Federal Civil Rights Act of 1964 as amended; Executive Order 11246, as amended; the Age Discrimination in Employment Act of 1973, as amended; Title IX of the Education Amendments Act of 1972; the Food Stamp Act of 1977, as amended; the Welfare and Institutions Code Section 1000; DPSS Operations Handbook Section 21; the Americans with Disabilities Act (ADA) of 1990; and other applicable nondiscrimination laws.

The SUBCONTRACTOR is required to complete and return the "Certificate of Non-Discrimination," attached hereto as EXHIBIT 4, which is incorporated herein by reference, as if set forth in full. Additionally, SUBCONTRACTOR staff working with CalWORKs/GAIN participants must undergo Civil Rights and Cultural Awareness Training provided by DPSS at a mutually agreeable date. INTERMEDIARY CONTRACTOR shall provide SUBCONTRACTOR with a supply of PA 607 - forms for participants' use should they wish to file a Civil Rights complaint. A copy of said PA-607 form is attached hereto as EXHIBIT 5, and is incorporated herein by reference, as if set forth in full.

INTERMEDIARY CONTRACTOR is required to conduct an investigation of civil rights complaints received from GAIN participants against SUBCONTRACTOR. SUBCONTRACTOR agrees that its staff shall be available at times agreeable to both parties to consult with INTERMEDIARY CONTRACTOR's staff as needed.

B. DISPLACEMENT GRIEVANCE

SUBCONTRACTOR shall ensure that labor unions and non-union employees are notified that GAIN participants are working or otherwise participating at specified work locations and that employees have the right to grieve displacement by such participants. Regulations establish a three-fold grievance process for regular employees who believe they have been displaced by Greater Avenues for Independence (GAIN) participants. Employees must be notified of the following:

1. GAIN participants have been included in the workforce at their location.
2. State law prohibits employers from using GAIN participants in a way that will cause employees to lose their job, or have their hours reduced.
3. Employers may not place GAIN participants in jobs that would be promotional opportunities for employees.
4. Employers may not violate any personnel rules when including a GAIN participant in the workforce.

Grievance procedures for both the Work Experience and Work Study programs are available through the City of Hawthorne, JTDD-GAIN, 11539 Hawthorne Blvd., 5th Floor, Hawthorne, CA 90250. All complaints against an employer must be in writing and contain the following information:

1. The full name, address and telephone number of the employee.
2. The full name and address of the employer.
3. A clear and brief statement of the facts, including dates, which have led to the complaint.
4. A statement that this complaint has been filed under penalty of perjury.
5. The complaint must be sent to City of Hawthorne (at above listed address).

SUBCONTRACTOR agrees that its staff shall be available at times agreeable to both parties to consult with INTERMEDIARY CONTRACTOR's staff as needed on matters related to this section.

C. DRUG FREE WORKPLACE COMPLIANCE

SUBCONTRACTOR shall comply with Government Code Section 8355, in matters related to providing a drug-free workplace as follows:

1. Publish a statement notifying employees/participants that unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and specifying actions to be taken against employees/participants for violations, as required by Government Code Section 8355(a).
2. Establish a Drug-Free Awareness Program as required by Government Code Section 8355 (b), to inform employees/participants about all of the following:
 - a. The dangers of drug abuse in the workplace,
 - b. SUBCONTRACTOR'S policy of maintaining a drug-free workplace,
 - c. Any available counseling, rehabilitation and employee/participant programs,
 - d. Penalties that may be imposed upon employees/participants for drug abuse violations.

D. NON-DISCRIMINATION

SUBCONTRACTOR shall ensure that no portion of its programs shall in any way discriminate against, deny benefits to, deny employment to, or exclude from participation any person on the grounds of race, color, national origin, religion, sex, condition of disability, political affiliation or belief. Subcontractor further agrees not to employ legally-prohibited discriminatory practices of any kind and to take positive measures to assure that equal employment opportunities, including employment, training, and promotion in all job classifications are made available without regard to race, color, religion, sex, age, national origin, physical or condition of disability, marital status, political affiliation or belief as required by Federal and State Laws and regulations.

E. COMPLIANCE WITH OTHER LAWS

SUBCONTRACTOR agrees to comply with all applicable Federal, State, and local laws, rules, regulations and ordinances, and all provisions required thereby to be included herein, and are hereby incorporated by this reference. These shall include, but are not be limited to:

1. California Welfare and Institutions Code
2. State Department of Social Services Manual of Policies and Procedures
3. Social Security Act
4. Title 24, California Administrative Code-Energy Plan
5. Occupational Safety Act of 1970, as amended.
6. Family Economic and Security Act
7. American Recovery and Investment Act

SUBCONTRACTOR acknowledges that Los Angeles County has established a goal of ensuring that all individuals and businesses that benefit financially from the County through contracts are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon he County and its taxpayers.

SUBCONTRACTOR warrants and certify that to the best of its knowledge that it is now in compliance, and during the term of this Contract will maintain compliance, with Los Angeles County Code Chapter 2.206, unless Contractor qualifies for an exemption or exclusion.

F. HOLD HARMLESS

SUBCONTRACTOR shall release, indemnify, defend, and hold harmless INTERMEDIARY CONTRACTOR, the COUNTY and its agents, officers and employees from and against any and all loss, damage or expense arising out of or relating to, or by reason of any act or omission in performance of this subcontract by SUBCONTRACTOR or any of SUBCONTRACTOR'S officers and employees. Conversely, INTERMEDIARY CONTRACTOR, shall release, indemnify, defend, and hold harmless SUBCONTRACTOR, and its agents, officers and employees from and against any and all loss, damage or expense arising out of or relating to, or by reason of any act or omission in performance of this

subcontract by INTERMEDIARY CONTRACTOR, or any of INTERMEDIARY CONTRACTOR's officers, employees or participants.

III. RECORDS

A. CONFIDENTIALITY OF RECORDS

SUBCONTRACTOR agrees to comply and require employees to comply with the provisions of Section 10850 of the California Welfare and Institutions Code and Chapter 19-000 of the SDSS Manual of Policies and Procedures, Federal, State, and local laws, regulations, ordinances, and directives relating to confidentiality. SUBCONTRACTOR shall comply with the following provisions in matters relating to confidentiality:

1. All applications and records concerning an individual made or kept by any public officer or agency in connection with the administration of any provision of the Welfare and Institutions Code relating to any form of public social services for which grants-in-aid are received by this State from the Federal Government will be confidential and will not be open to examination for any purpose not directly connected with administration of such public social services.
2. No person will publish or disclose, or use or permit, or cause to be published, disclosed or used, any confidential information pertaining to an applicant or recipient. SUBCONTRACTOR agrees to inform its employees, agents, subcontractors and partners that any person who knowingly and intentionally violates the provisions of State law is guilty of a misdemeanor.
3. SUBCONTRACTOR agrees that all information and records obtained in the course of providing services to project participants shall be subject to confidentiality and disclosure provisions of applicable Federal and State statutes and regulations adopted pursuant thereto and no such information may be relayed to anyone except those employees of the Los Angeles County Department of Public Social Services (DPSS) so designated, GAIN contractors, as approved by the County, and organizations approved and designated by DPSS.

B. RECORDS RETENTION

SUBCONTRACTOR agrees to maintain all records pertaining to participant attendance for five years following the term of the subcontract agreement or until all pending Federal, State, COUNTY or

INTERMEDIARY CONTRACTOR audits are completed, whichever is later. Upon request, the SUBCONTRACTOR shall make these records available to all authorized Federal, State, (including the Auditor General), COUNTY and INTERMEDIARY CONTRACTOR personnel. Such records shall be kept in the County of Los Angeles, State of California and be accessible to authorized Federal, State, COUNTY representatives, and representatives of INTERMEDIARY CONTRACTOR for the retention period specified herein.

IV. TERMINATION OF AGREEMENT

A. TERMINATION WITHOUT CAUSE

Either party may, at any time during the term of this agreement hereof, terminate it without cause by giving thirty (30) days written notice to the other party.

1. Should INTERMEDIARY CONTRACTOR give notice of termination, upon receipt, SUBCONTRACTOR shall immediately cease all work under this Subcontract, unless the notice otherwise expressly provides. In the event this Subcontract is terminated by SUBCONTRACTOR, it shall be deemed released from any liability for any work assigned but not completed as of the effective date of such termination.
2. Should SUBCONTRACTOR terminate this agreement, SUBCONTRACTOR shall defend, indemnify and hold INTERMEDIARY CONTRACTOR, its employees, officers and agents harmless from any and all claims of liability or damage against INTERMEDIARY CONTRACTOR resulting from such termination.

B. TERMINATION WITH CAUSE

INTERMEDIARY CONTRACTOR may immediately terminate this Agreement upon written notification to SUBCONTRACTOR without complying with Subsection A above for any of the following reasons:

1. If INTERMEDIARY CONTRACTOR determines that there is an immediate danger of injury to participant(s) or increased potential liability to INTERMEDIARY CONTRACTOR.
2. Violation by SUBCONTRACTOR of any term of this Subcontract.

3. Failure by SUBCONTRACTOR to accept and/or implement any additional conditions that may be required by law.

V. REQUIRED FORMS

When necessary, SUBCONTRACTOR shall complete the forms listed on EXHIBIT 6, which are attached hereto, and are incorporated herein by reference, as if set forth in full. Such forms shall be completed according to the conditions described in the Scope of Work, or as directed by INTERMEDIARY CONTRACTOR or the COUNTY. These forms shall be provided by either the INTERMEDIARY CONTRACTOR or a COUNTY Gain Service Worker when needed to ensure program integrity.

VI. CONTRACT OBLIGATION

The signatories hereto assure that in providing activities for the CalWORKs/Greater Avenues for Independence (GAIN) program, Work Experience, Work Study and/or Community Service they will comply with the terms set forth in this subcontract agreement including all Exhibits thereto, which collectively constitute the entire agreement.

VII - ENTIRE AGREEMENT

This agreement, including all Exhibits referenced, constitutes the entire agreement of the parties and supersedes any previous oral negotiations or written expressions of intent between the parties.

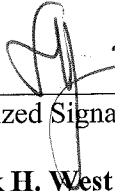
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IN WITNESS WHEREOF, the parties herein have executed this Agreement as of the date first above written.

APPROVED AS TO FORM
January 10, 2012
ROBERT E. SHANNON, City Attorney
By Gary J. Anderson
GARY J. ANDERSON
DEPUTY CITY ATTORNEY

SUBCONTRACTOR

 Assistant City Manager

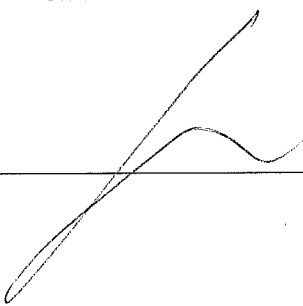
Authorized Signature
Patrick H. West

Name (please print)
City Manager

Title

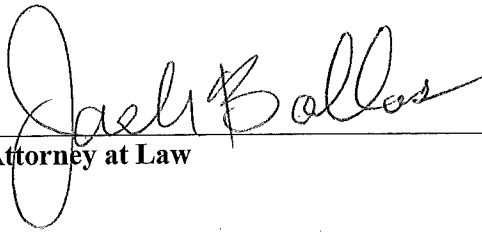
EXECUTED PURSUANT
TO SECTION 301 OF
THE CITY CHARTER.

CITY OF HAWTHORNE



Jan Vogel, Executive Director

APPROVED AS TO FORM:



Jack Ballas, Attorney at Law

EXHIBIT 1

WORK EXPERIENCE//WORK STUDY/Community Service

STATEMENT OF WORK

General Description of Work Experience

Work Experience (WEX) is a GAIN work activities in which participants receive salaried or non-salaried work assignments with public, private for-profit or private non-profit organizations.

The goal of WEX is to prepare participants for permanent unsubsidized employment and self-sufficiency.

A WEX assignment should provide work behavior skills, acquisition of new skills, enhancement of existing or recently acquired skills and employment references to use when seeking salaried employment. A successful WEX work assignment will result in helping a participant transition to salaried employment.

Participation in WEX is limited to a period no longer than twelve (12) months.

General Description of Work Study

Work Study is a GAIN work assignment that provides part-time paid internships to CalWorks participants enrolled in Community Colleges to help offset college expenses at Public Agencies, assisting them in meeting their work requirements under Temporary Assistance for Needy Families Reauthorization (TANF) legislation. CalWorks participants earn \$9.00 per hour working at subcontracted agencies on or off campus for a period of time to be determined by the college/County. Community Colleges will fund a portion of the hourly wage with the County to fund the remaining percentage and employer taxes. Wages paid to participants will be paid by the Intermediary Contractor as Employer of Record. Worksites may be with public, private for-profit or private non-profit organizations.

General Description of Community Service

Community Service is a non-salaried work activity performed eligible CalWORKs participants in the public or private non-profit sector. While fulfilling an unmet community need, they are intended to provide participants with jobs skills training that may lead to full-time unsubsidized employment and self-sufficiency.

General Provisions

- A. SUBCONTRACTOR shall ensure that a WEX/WS/CS position will not be created as the result of, or may not result in:
1. The displacement of current employees, including overtime currently worked by these employees.
 2. The filling of established unfilled positions, unless the positions are unfunded in a public agency budget.

3. The filling of positions which would otherwise be promotional opportunities for current employees.
 4. The filling of positions, prior to compliance with applicable personnel procedures or provisions of collective bargaining agreements.
 5. The filling of a position created by termination, layoff, or reduction in workforce.
 6. The filling of a work assignment customarily performed by a worker in a job classification within a recognized collective bargaining unit in that specific work site, or the filling of a work assignment in any bargaining unit in which funded positions are vacant or in which regular employees are on layoffs.
- B. SUBCONTRACTOR shall assist and encourage qualified WEX/WS/CS participants to compete for job openings within the SUBCONTRACTOR'S organization.
- C. Public agency SUBCONTRACTORS shall ensure to the extent permitted under federal or state law, local ordinances, applicable bargaining agreements or personnel procedures, that time worked in the WEX/WS/CS position will apply toward the participant's seniority, *if applicable* in merit system employment positions.
- D. Public agency SUBCONTRACTORS, to the extent possible, shall allow GAIN WEX/WS/CS participants to participate in:
1. Classified service examinations equivalent to the WEX/WS/CS position.
 2. All open and promotional examinations for which experience in the position or other relevant experience would qualify the person to the extent permitted under federal or state law, local ordinances, applicable collective bargaining agreements, or personnel procedures.
- E. Upon request SUBCONTRACTOR shall provide WEX/WS/CS assignments within the GAIN Priority Occupations, or the Los Angeles County growth occupations.
- F. SUBCONTRACTOR shall comply with the six month review requirements, if appropriate, consisting of a discussion with the GAIN Services Manager, participant's supervisor and participant regarding the assignment, the participant's progress in the assignment and job search activities.
- G. The California Department of Social Services (CDSS) contracts with the State Compensation Insurance Fund (SCIF) to administer the workers' compensation benefits to GAIN participants assigned to non-salaried WEX/WS/CS activities.
- H. Subcontractor shall provide the same job safety and working conditions as provided to regular employees.
- I. Subcontractor shall supervise all participants at the Worksite and require participants conformance with Subcontractor's standard of conduct for agency personnel. Participants are not to be considered a part of the Subcontractor's personnel. Subcontractor shall provide an orientation to each participant prior to beginning work

which includes worksite rules, procedures, participant responsibilities and reporting requirements.

- J. During the training period, Subcontractor shall expose participants to all customary and normal requirements of the job. Worksite shall provide enhanced training for participants, whenever necessary, to enable participants to master the job.
- K. Subcontractor shall provide facilities which are adequate to fulfill the requirements of this Agreement.
- L. Subcontractor shall Prepare and submit a bi-weekly evaluation and discuss the evaluation with participants.
- M. Subcontractor shall notify Intermediary Contractor immediately of any changes in designation of personnel who will be supervising participants. This includes temporary designations of more than 2 days duration.
- N. Subcontractor shall allow release time for counseling, educational training, unsubsidized job interviews and other related activities only with written authorization from Intermediary Contractor or County Representative.
- O. Subcontractor shall adhere to policies and rules as discussed in the Supervisor Handbook. The Supervisor Handbook will be provided to Subcontractor upon execution of this agreement.
- P. Subcontractor shall fully cooperate with authorized representatives of the Intermediary Contractor, County, State and Federal governments including independent auditors. In particular, cooperation is required with respect to those representatives seeking to interview any program participant or staff member of the Subcontractor, as well those representatives who evaluate, inspect and/or monitor facilities and operations of the Subcontractor that are directly involved in the implementation of programs funded through this Agreement, including program records.
- Q. Subcontractor shall provide an orientation to participants that explains the program's purpose, applicable procedures, and the right to file a grievance in accordance with County regulations.
- R. Should Subcontractor employ a participant as staff, then said participant shall cease to be a participant in the WEX/WS/CS programs.
- S. Subcontractor shall provide Worksite supervisors with appropriate written materials describing the tasks necessary for the performance of his/her duties, including a copy of this Agreement and WEX/WS/CS regulations and policies.
- T. Subcontractor shall assist the Worksite supervisor in resolving any problems concerning the participant's performance on the job.
- U. **In the event of injury or death of a GAIN participant** in a WEX/WS/CS assignment, the SUBCONTRACTOR shall immediately contact: The City of Hawthorne, Job Training and Development Dept. (JTDD)-GAIN, at (310) 970-7796 within 24 hours of occurrence or knowledge of occurrence.

SUBCONTRACTOR shall also:

- Provide the injured participant with State Compensation Insurance Form (SCIF) 3301.
- Complete SCIF Form 3367.
- Obtain completed SCIF Form 3301 from participant and submit Forms 3301 and to, GAIN Intermediary Contractor, City of Hawthorne, 11539 Hawthorne Blvd., 5th Floor, Hawthorne, CA. 90250.

In the event of extreme injury or death of a GAIN participant immediately contact:

**Tracey Atkins, GAIN Manager
South Bay Workforce Investment Board
11539 Hawthorne Blvd., Ste. 500
Hawthorne, CA 90250
(310) 970-7796**

and

**Lorraine Sinelkoff, CalWORKs/GAIN Program Division
Los Angeles County Department of Public Social Services
12860 Crossroads Parkway South
City of Industry, CA 91746
(562) 908-5863**

- V. During the assigned work period, the SUBCONTRACTOR shall provide each participant with:
1. Instruction as well as reasonable and proper supervision regarding duties/work activities.
 2. Safety instructions and equipment necessary for protection against injury and damage, in accordance with OSHA guidelines.
 3. The same working conditions as employees similarly employed, e.g., coffee breaks, lunch breaks.

Special Provisions

- A. INTERMEDIARY CONTRACTOR has contracted with the COUNTY to serve as Employer of Record for the Transitional Subsidized Employment project. SUBCONTRACTOR agrees to provide services specifically related to the Transitional Subsidized Employment program, including but not limited to the following:
1. Maintain participant Time Sheets and forward them to INTERMEDIARY CONTRACTOR or other agent on a bi weekly basis.

2. Distribute paychecks delivered by INTERMEDIARY CONTRACTOR to participants participating in the Transitional Subsidized Employment program.
3. Maintain a signature log recording the distribution of paychecks to participants.
4. Immediately inform referral agency, INTERMEDIARY CONTRACTOR and the participant's GAIN SERVICE WORKER should the participant ceases to attend, withdraws from, or is terminated from his/her assignment.

Tracking and Reporting

INTERMEDIARY CONTRACTOR, the COUNTY or authorized referral agent shall supply all necessary CalWORKs/GAIN forms.

SUBCONTRACTOR shall comply with WEX/WS/CS tracking and reporting requirements and instructions for completing forms referenced in EXHIBIT 6 hereto.

- A. SUBCONTRACTOR shall schedule a WEX/WS/CS enrollment appointment for GAIN participants by telephone when contacted by an authorized referral agent/GSW. Participants will be referred by the GSW on Service Provider Referral Form GN 6006. The referral form will contain the name and telephone number of the GSW.
- B. SUBCONTRACTOR shall complete as appropriate (entering the planned completion date) the GN 6006 referral form and mail the original completed, signed and dated to the GSW within eight (8) workdays after the receipt of same.
- C. If requested, SUBCONTRACTOR shall mail a copy of the GN 6006 to the INTERMEDIARY CONTRACTOR, City of Hawthorne-GAIN, 11539 Hawthorne Blvd., 5th Fl., Hawthorne, CA 90250.
- D. Upon enrollment in a WEX/WS/CS assignment, SUBCONTRACTOR shall complete a Job Specification Sheet. A copy of this Job Specification Sheet shall be mailed to the GSW attached to the GN 6006, a copy shall be given to the participant, and a copy shall be retained in the file.
- E. SUBCONTRACTOR shall reschedule the enrollment date when requested to do so by the GAIN participant or the GSW. If an enrollment date is rescheduled, confirmation of the new enrollment will be made by a telephone call to the authorized referral agent/GSW within one (1) workday. SUBCONTRACTOR shall refer back to the GSW any participant who contacts the SUBCONTRACTOR after SUBCONTRACTOR has reported the participant's failure to keep the appointment.
- F. SUBCONTRACTOR shall notify the GSW within five (5) workdays of any change in circumstances that will affect program participation on the Notification of Change from Service Provider (GN 6007B), including, but not limited to the following:
 1. Prior to the scheduled start date and time, the participant called and re-scheduled the appointment.
 2. The participant did not keep the scheduled appointment to enroll in or to start the WEX/WS/CS assignment;

3. The WEX/WS/CS assignment is completed.
 4. The participant obtains employment; during or immediately after the WEX/WS/CS assignment.
 5. The participant refuses employment.
 6. The participant fails to attend or to satisfactorily progress in his/her WEX/WS/CS assignment.
 7. The participant needs a change in supportive services.
 8. Any other change relevant to GAIN and/or CalWORKs case.
- G. If SUBCONTRACTOR determines that the given WEX/WS/CS work/training assignment is inappropriate for a participant, SUBCONTRACTOR's recommendation for change in assignment must be made within thirty (30) workdays from the program start date. Recommendations for change must be made via the GN 6007B form.
- H. SUBCONTRACTOR shall cancel or stop WEX/WS/CS as requested by County on Service Provider Cancellation/Stop Notice (GN 6011).
- I. Each and every quarterly period, or at the midpoint, if the training program is less than three months, SUBCONTRACTOR is required to complete a Progress/Attendance Report (GN6070) provided by the GAIN participant. The completed GN6070 shall be returned to the GSW by either the participant or SUBCONTRACTOR.

EXHIBIT 2

SUBCONTRACTOR EMPLOYEE

ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT

GENERAL INFORMATION:

Your Community Service (CS)/Work Experience (WEX) Work Study (WS) provider, _____, has entered into an agreement with the City of Hawthorne's Job Training and Development Department (hereinafter referred to as the "Intermediary Contractor") to provide various services to the Intermediary Contractor and the County of Los Angeles. As a result, your signature is required on this Subcontractor Employee Acknowledgment and Confidentiality Agreement.

PARTICIPANT ACKNOWLEDGMENT

I understand that _____ is my sole CS/WEX/WS/CS provider for purposes of this training.

I rely exclusively upon GAIN/CalWORKs and Intermediary Contractor for payment of salary and any and all other benefits payable to me or on my behalf during the period of this CS/WEX/WS/CS training.

I understand and agree that I am not an employee of the CS/WEX/WS/CS provider, INTERMEDIARY CONTRACTOR or of Los Angeles County for any purposes other than the CS/WEX/WS/CS program and that I do not have and will not acquire any rights or benefits of any kind from the CS/WEX/WS/CS provider, INTERMEDIARY CONTRACTOR or the County of Los Angeles during the period of this CS/WEX/WS/CS training.

I understand and agree that I do not have nor will I acquire any rights or benefits pursuant to any agreement between my CS/WEX/WS/CS training provider, _____ and the INTERMEDIARY CONTRACTOR or the County of Los Angeles.

CONFIDENTIALITY AGREEMENT

As a CS/WEX/WS/CS participant of _____ you may be involved with work pertaining to County Services and if so, you may have access to confidential data pertaining to persons and or other entities who receive services from the County of Los Angeles. The County of Los Angeles and all of its contractors and subcontractors have a legal obligation to protect all confidential data, especially data concerning welfare recipient records. Since you may be involved with work with welfare recipients, the County must ensure that you, too, will protect the confidentiality of data. You must sign this confidentiality agreement as a condition of your work assignment to be provided to _____ for the County of Los Angeles and/or the Intermediary Contractor.

Please read the Contractor/Subcontractor Participant Acknowledgment and Confidentiality Agreement carefully and take your time to consider it before signing.

I hereby agree that I will not divulge to any unauthorized personal data obtained while assigned at this work site pursuant to the agreement between _____ and the INTERMEDIARY CONTRACTOR or the County of Los Angeles.

I agree to report any and all violations of the above by any other person and/or by myself to any immediate supervisor and I agree to ensure that said supervisor reports such violation to the County of Los Angeles Department of Public Social Services. I agree to return all confidential materials to my immediate supervisor upon termination of my CS/WEX training with _____ or completion of the presently assigned work tasks, whichever occurs first.

I acknowledge that violation of this acknowledgment and agreement may subject me to civil and/or criminal action and that the County of Los Angeles will seek all possible legal redress.

CS/WEX/WS/CS PARTICIPANT:

Signature

Date

Print-Name

EXHIBIT 3

DEPARTMENT OF PUBLIC SOCIAL SERVICES

Welfare-to-Work Division

AGENCY RATING SYSTEM

CITY OF LONG BEACH - PRM

Agency Name

SERVICES OFFERED BY YOUR AGENCY	YES	NO
Job Placements within the organization that are permanent positions.	X	
On-Site classroom education & training to supplement working hours.	X	
Guidance and Counseling with direct supervision.	X	
Develops individualized learning plan with the participant.	X	
Site is easily accessible by Public Transportation.	X	
Assist with Job Search placements.	X	
Intermediate Hard Skills Training (e.g., Data Processing)		X
Advance Hard Skills Training (e.g., Pharmacy Tech, Computer Programmer)		X
Mentoring.	X	
<u>Training for a Job/Occupation with a Prevailing Wage of:</u>		
\$ 8 -\$ 8.99	X	
\$ 9 - \$ 9.99	X	
\$ 10 and above w/specialized training (specify)	X	
Open Saturdays / Sundays.	X	
Work with participants in languages other than English.	X	

EXHIBIT 4

CERTIFICATION OF NON-DISCRIMINATION

CITY OF LONG BEACH
Subcontractor's Name

3447 Atlantic Ave., Long Beach, CA 90807
Address

95-6000-733
Internal Revenue Service Employer Identification Number

GENERAL


In accordance with Subchapter VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, the Food Stamp Act of 1977, and the Americans with Disabilities Act of 1990, the Contractor, supplier, or proposer certifies and agrees that all persons serviced by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, color, religion, ancestry, national origin, age, condition of disability, marital status, political affiliation or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

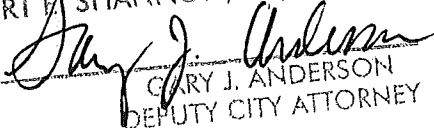
SUBCONTRACTOR'S CERTIFICATION

(circle one)

- 1. The Subcontractor has a written policy statement prohibiting discrimination in providing services and benefits. Yes No
- 2. The Subcontractor periodically monitors the equal provision of services to ensure nondiscrimination. Yes No
- 3. Where problem areas are identified in equal provisions of services and benefits, the Subcontractor has a system for taking reasonable corrective action within a specified length of time. Yes No

PATRICK H. WEST, CITY MANAGER
Name and Title of Signatory (please print)

Signature  Assistant City Manager
EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER. Date 1-27-12

APPROVED AS TO FORM
January 10, 2012
ROBERT F. SHANNON, City Attorney
By  GARY J. ANDERSON
DEPUTY CITY ATTORNEY

COMPLAINT OF DISCRIMINATORY TREATMENT

TO : DEPARTMENT OF PUBLIC SOCIAL SERVICES
CIVIL RIGHTS AND LANGUAGE SERVICES SECTION
12860 CROSSROADS PARKWAY SOUTH
CITY OF INDUSTRY, CALIFORNIA 91746

CASE NAME :

CASE NUMBER:

I, _____, hereby file this complaint of discriminatory treatment
(Please print your name) and request that an investigation be conducted.

I believe I was discriminated against because of my:

<input type="checkbox"/> RACE	<input type="checkbox"/> RELIGION	<input type="checkbox"/> COLOR
<input type="checkbox"/> NATIONAL ORIGIN	<input type="checkbox"/> SEX	<input type="checkbox"/> AGE
<input type="checkbox"/> POLITICAL AFFILIATION	<input type="checkbox"/> MARITAL STATUS	<input type="checkbox"/> DISABILITY

DATE OF OCCURENCE : _____

NAME(S) AND TITLE(S) OF THE PERSON(S) WHO I BELIEVE DISCRIMINATED AGAINST ME :

THE ACTION, DECISION OR CONDITION WHICH CAUSED ME TO FILE THIS COMPLAINT IS AS FOLLOWS :

I WISH TO HAVE THE FOLLOVING CORRECTIVE ACTION TAKEN :

(SIGNATURE) (DATE) ADDRESS : _____

TELEPHONE : _____

EXHIBIT 6

GAIN REQUIRED FORMS FOR WEX/WS/CS SUBCONTRACTORS

Sample forms included in this section are to be completed or processed by SUBCONTRACTOR according to the terms and conditions hereinabove set forth or as directed by INTERMEDIARY CONTRACTOR or the COUNTY. The forms will be provided by either the INTERMEDIARY CONTRACTOR, authorized referral agent, or the COUNTY GAIN service worker.

Forms to be completed or processed by SUBCONTRACTOR include but are not limited to:

1. GN 6006-Service Provider Referral
2. GN 6007B-Notification of Change From Service Provider
3. GN 6070-Progress/Attendance Report
4. WEX/CS Job Specification Sheet
5. GN 6011, Service Provider Cancellation/Stop Notice
6. State of California Insurance Forms-SCIF 3367 and SCIF 3301
7. Worksite Certification In-Kind Claim Form

CITY OF LONG BEACH
CERTIFICATE OF SELF-INSURANCE



With respect to:

(Agreement Title/Program
and subject/location)

Transitional Subsidized Employment Program (TSEP) dated July 1, 2011 until
June 30, 2012

City of Long Beach
Program Coordinator

Melu Habacon Phone (562) 570-3744
Workforce Development Bureau

Between the City of Long Beach and

Certificate Holder:
(Name and Location)

City of Hawthorne/South Bay Workforce Investment Board, Job Training and Development
Dept./G.A.I.N. Unit, 11539 Hawthorne Blvd., Ste. 500, Hawthorne, CA 90250

Contact Person

David Nelms, EDA II, ATTN: GAIN UNIT Phone (310) 970-7796
Fax (310) 970-7112

Copy to:

Melu Habacon, Community Development Department

Type of Coverage:

Commercial general liability equivalent in scope to CG 00 01 10 93 of \$2,000,000 per
occurrence and \$2,000,000 in aggregate; commercial automobile liability insurance equivalent in scope to CA 00
01 06 92 of \$1,000,000 combined single limits; statutory workers' compensation and employer's liability of
\$1,000,000 per accident; claims-made professional liability in an amount not less than \$1,000,000 per claim and
aggregate covering the services provided pursuant to the Agreement

This coverage will terminate upon completion or satisfaction of the requirements of said Program or may be terminated sooner pursuant to terms of said Program. Coverage afforded hereunder is primary and any insurance or self-insurance of Certificate Holder shall not contribute with it.

If any of the coverages described in this Certificate are changed or withdrawn, the City of Long Beach will mail the Certificate Holder thirty (30) days prior written notice by registered mail, but failure to mail such notice shall impose no obligation or liability of any kind upon the City of Long Beach, its officials, agents or employees.

This Certificate of Self-Insurance is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage evidenced herein.

Additional Interest: The City of Hawthorne, its officials, officers, agents and employees and the County of Los Angeles, its Special Districts, its Officials, Officers, and Employees are additional covered interests with respect to activities of the City under the said Agreement/Program per the attached endorsement.

For further information or in the event of a claim,
contact:

City of Long Beach
Attn: Risk Management
333 West Ocean Blvd., 10th Floor
Long Beach, CA 90802
(562) 570-6754
(562) 570-5375 (fax)

Certified by:

Michael Alio
Risk Manager

Certificate no. 2012-002C

Coverage period: July 1, 2011 to June 30, 2012

Date issued: January 5, 2012

CITY OF LONG BEACH
ADDITIONAL COVERED INTEREST ENDORSEMENT
TO CERTIFICATE NO. 2012-002C



Additional Covered Interest:

The City of Hawthorne, its officials, officers, agents and employees and the County of Los Angeles, its Special Districts, its Officials, Officers, and Employees

With Respect to (Agreement or Program):

Transitional Subsidized Employment Program (TSEP) dated July 1, 2011 until June 30, 2012

The additional interest coverage provided by this endorsement applies only with respect to liability arising out of activities of the City of Long Beach with respect to the above described Agreement or Program, provided that such liability is due to the sole negligence of the City. In no event shall this endorsement extend the limits provided in the certificate of self-insurance, or amend the coverage provided in the certificate of self-insurance except as to the additional interest coverage stated herein.

Certified by:

A handwritten signature in black ink that reads "Michael Alio".

Michael Alio
Risk Manager

Coverage Period*: 07/01/11 to 06/30/12

**unless coverage is terminated sooner pursuant to the terms and conditions of the Agreement or Program.*

Endorsement no. 2012-002E

Date issued: January 5, 2012



CITY OF LONG BEACH

DEPARTMENT OF HUMAN RESOURCES

333 West Ocean Boulevard 13th Floor • Long Beach, CA 90802

Automobile Insurance Waiver Letter

Neither participant vehicles nor company owned or operated vehicles will be used to perform any of the services required to be performed under this Agreement: California Work Opportunity and Responsibility to Kids (CalWORKs) Greater Avenues for Independence (GAIN) – Work Experience/Work Study/Community Service Combined Agreement

Sincerely,

Melu Habacon
Contracts & Procurement Coordinator
Pacific Gateway
562.570.3744

EMPLOYER: You must, by law, post the information contained on this notice in a conspicuous location frequented by employees, where employees may easily read such notice during the course of the day. You must post this notice in English and Spanish, if your staff includes Spanish-speaking employees. Insert the appropriate phone numbers, addresses and date in the spaces indicated on this employee notice. You must also post the Employee's Guide to the State Fund MPN brochure in close proximity to this notice. Failure to comply with this regulation could result in penalties.

NOTICE TO EMPLOYEES

STATE
COMPENSATION
INSURANCE
FUND

How to get emergency medical treatment for an industrial injury or illness. If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer. Tell the health-care provider who treats you that your injury or illness is job-related, and, if possible, give your employer's workers' compensation carrier information.

Types of events, injuries, and illnesses that workers' compensation covers. You could get hurt by one event at work, such as hurting your back in a fall, or by repeated exposures at work, such as hurting your wrist as the result of doing the same motion over and over.

Report all injuries to your supervisor or employer representative right away. Immediately notify your supervisor or employer representative of any work-related injury or illness. Your employer will provide you with a notice of potential eligibility for benefits, and a claim form on which you must describe the circumstances of the injury. Return the completed form to your supervisor. If you have any questions or would like more details about workers' compensation benefits, please see your supervisor or call State Compensation Insurance Fund (State Fund).

Time limits for reporting injuries. Generally, the law requires you to provide your employer with notice of your injury within 30 days of the date of injury. In addition, if you disagree with any of our actions, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board (WCAB) within the approved time limit. You must file an Application for Adjudication of Claim within one year of the date of injury, or one year from the last furnishing of indemnity or medical-treatment benefits by your employer or State Fund. It is important that you act promptly so you don't risk losing your benefits because you waited too long.

Your right to receive medical care. You have the right to receive medical care, at your employer's expense, to help you recover from an injury or illness resulting from your work. Within one day after you file a claim form, the law requires your employer to authorize medical treatment as required and limited by the law, until the claim is accepted or rejected, up to a limit of \$10,000 in total. Medical care may include doctors, hospital services, physical therapy, lab tests, x-rays, medicines, and related reasonable transportation expenses. For injuries on or after January 1, 2004, there are limits on the number of chiropractic, occupational therapy, and physical therapy visits. These limits do not apply to visits after a surgery when they are based on a postsurgical treatment utilization schedule established by the administrative director (AD). All medical treatment is provided in accordance with the medical treatment utilization schedule.

What is the State Fund Medical Provider Network? You should have received information regarding the State Fund Medical Provider Network (MPN) from your employer at your time of hire or when the MPN became implemented by your employer.

The State Fund MPN is a selected network of physicians and other medical service providers to provide treatment to workers injured on the job. A copy of the State Fund MPN brochure should be posted near this poster which will explain how to use the MPN. You can request a copy of this brochure by calling (888) 222-3211 or download the brochure from the State Fund website at www.statefundca.com.

What is the role and function of the primary treating physician?

Your treating doctor will decide what type of medical care you'll need for your injury or illness, determine when you can return to work, help identify the kinds of work you can do safely while recovering, refer you to specialists, if necessary, and write medical reports that will affect the benefits you receive.

If you have predesignated a personal physician prior to your work injury, then you may receive treatment from your predesignated doctor.

Your predesignated physician must meet the following requirements:

- Must be your regular physician.
- Must be your primary care physician or your physician's integrated multispecialty medical group.
- Must be licensed by Business & Professions Code.
- Must have previously provided your treatment.
- Retains your medical records, including medical history.
- Agrees to be your predesignated physician.

To predesignate, you must give your employer the name and address of your personal physician or your personal physician's integrated multispecialty medical group in writing, before you are injured.

If you do not predesignate, your employer will arrange your initial treatment with a physician within the MPN. After this initial treatment, you will be able to choose your physician within the MPN.

If you were injured and are receiving treatment by a non-MPN doctor, and you did not predesignate, you may be required to change to a physician within the MPN.

City of Long Beach / TSE WORKERS ONLY
Long Beach Medical Clinic
1250 Pacific Ave.
Long Beach, CA 90813
(562) 437-0837

Our workers' compensation carrier is:

STATE COMPENSATION INSURANCE FUND
24-HOUR CLAIMS REPORTING CENTER
(888) 222-3211 toll-free

Can I predesignate a chiropractor or acupuncturist? No. But, if the MPN is not applicable and you have identified a personal chiropractor or acupuncturist in writing prior to the date of your injury, you may request a change from the employer's physician to your personal chiropractor or acupuncturist.

This request for a change of physician may be made at any time after the initial treatment provided by your employer.

Contact either your employer or your employer's workers' compensation carrier or claims administrator for further information.

Disability benefits. If hospitalized, or unable to work for more than three days, you will receive temporary disability (TD) benefits equal to two-thirds of your average weekly pay, up to a legal maximum per week. For dates of injury on or after January 1, 2008, no TD will be paid beyond 104 compensable weeks within a period of five years from the date of injury. Exempt are certain injuries that typically take longer to heal; they are subject to a cap of 240 weeks within a five-year period. If your injury results in a permanent disability that decreases your ability to work, you will receive additional payments.

Death benefits. If a work injury causes death, your dependents will receive a benefit amount.

Supplemental Job Displacement Benefit. For injuries arising on or after January 1, 2004, a nontransferable voucher is payable to a state-approved school if your injury results in permanent disability, and prevents you from returning to work within 60 days after TD ends, and your employer does not offer you modified or alternative work.

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or for testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

An information and assistance officer at the state Division of Workers' Compensation (DWC) can provide information and forms and help resolve problems with your claim. You can contact the nearest information and assistance officer as follows:

Location

Toll-free telephone (800) 736-7401
Website: www.dwc.ca.gov or www.dir.ca.gov/dlse

Your employer may not be liable for the payment of workers' compensation benefits for an injury that arises out of an employee's voluntary participation in any off-duty recreational, social, or athletic activity that is not a part of the employee's work-related duties.

Medical Provider Network. For a list of State Fund's network providers in your area, please call the Claims Reporting Center's toll-free number: (888) 222-3211 or you can write us at:

State Compensation Insurance Fund.
Attn: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

A regional directory of State Fund's medical providers is also available from MEDfinder MPN at www.statefundca.com or sending an email to scifmpn@scif.com.

MPN Effective Date: _____

WARNING: It is unlawful to file a false or fraudulent workers' compensation claim or to make a false or fraudulent written or oral statement in support of or in opposition to a workers' compensation claim, or to aid or conspire with anyone to commit such fraud. If convicted, the penalty is up to 5 years in prison or a fine of up to \$150,000 or double the value of the fraud, whichever is greater, or both imprisonment and fine. Restitution and other penalties may also apply.

This notice, which is in accordance with Labor Code Section 3550, has been approved by the administrative director of the Division of Workers' Compensation (DWC).
13708 (Rev. 09/10)

©2010 State Compensation Insurance Fund

ADVISORY NOTICE

TO: All Transitional Subsidized Employment Program (TSE) Providers
FROM: City of Hawthorne – Intermediary Contractor for the GAIN Program
RE: Injuries to TSE Participants.

This Notice is intended as a reminder to all TSE providers who have participants that may have been injured while at your site. Notice is given as to the following procedures:

1. If a participant is injured, the participant's supervisor or a representative of your agency must take the injured participant to the **assigned** medical facility or to an Industrial Injury Department as you would for your organization's own employees. After an examination by a physician, a copy of said physician's injury report is to be obtained by your organization.
2. Per regulations, your organization is responsible to fill out an Employer's Report of Injury Form (SCIF-3067) and submit to the participant a copy of an Employee's Claim form (SCIF-3301). Note: It is the responsibility of the **participant** to fill out the SCIF-3301.
3. Intermediary Contractor – Contact Maribel Smith of the City of Hawthorne – GAIN unit at 310.970.7796 within 24 hours of your organization's learning of any injury requiring medical attention. Please FAX a copy of the SCIF-3067, SCIF-3301, along with the physician's injury report to 310.970.7712, Attention: Maribel Smith.

From this point forward, any and all necessary documentation/procedures will be handled by Intermediary Contractor. Please reference the Worker's Compensation section of the Supervisor's Handbook and your organization's TSE contract for additional information. We have enclosed copies of the SCIF-3067 and SCIF-3301 forms for your convenience.

Should you have any questions or comments regarding the above or any Worker's Compensation procedure, please call me @ 310.970.7796 at your earliest convenience.

TRACEY ATKINS
GAIN Manager

EMPLEADOR: Según la legislación vigente, usted debe publicar la información incluida en este aviso en un lugar bien visible al que los empleados acudan con frecuencia, de manera que puedan leerlo con facilidad en el transcurso del día. El aviso debe ser publicado en inglés y en español, si hubiera empleados que hablan español entre su personal. Agregue las direcciones, la fecha y los números de teléfono correspondientes en los espacios indicados en este aviso dirigido a los empleados. Usted también debe publicar la Guía del empleado para la State Fund Medical Provider Network en proximidad a este aviso. Usted incurrirá en sanciones si no cumple con esta disposición.

AVISO A LOS EMPLEADOS

STATE
COMPENSATION
INSURANCE
FUND

Cómo solicitar atención médica de emergencia por enfermedades o lesiones en el trabajo. Si necesita cuidado de emergencia, llame al 911 para inmediatamente pedir ayuda del hospital, ambulancia, departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, póngase en contacto con su empleador. Coméntele al proveedor de cuidados de la salud que su lesión o enfermedad es laboral y, de ser posible, dele la información de la compañía de seguros de compensación a los trabajadores de su empleador.

Tipos de acontecimientos, lesiones y enfermedades incluidos en la cobertura de la compensación a los trabajadores. En el trabajo, usted puede lesionarse por un acontecimiento (por ejemplo, lastimarse la espalda por una caída) o bien, por la reiteración de una determinada actividad (por ejemplo, lastimarse la muñeca por la repetición constante de un movimiento).

Reporte todas las lesiones a su supervisor o al representante del empleador de inmediato. Inmediatamente notifique a su supervisor o al representante del empleador sobre cualquier lesión o enfermedad relacionada al trabajo. El empleador le suministrará un aviso de beneficiario potencial y un formulario de reclamos en el que deberá describir las circunstancias de la lesión. Una vez que complete el formulario, deberá devolverlo al supervisor. Si tiene dudas o desea obtener más información sobre los beneficios de compensación a los trabajadores, consulte al supervisor o llame a State Compensation Insurance Fund (State Fund), la compañía estatal de seguros de compensación a los trabajadores.

Plazos de tiempo para informar lesiones. Según la ley, el plazo del que normalmente dispone para notificar la lesión al empleador es de 30 días a partir de la fecha de dicha lesión. Además, si no está de acuerdo con alguna de nuestras medidas, para proteger sus derechos debe iniciar las acciones correspondientes ante el Workers' Compensation Appeals Board (WCAB) dentro del plazo de tiempo autorizado. Debe presentar una solicitud de arbitraje de reclamo, denominada Application for Adjudication of Claim, antes de cumplirse un año de la fecha de la lesión o de la última indemnización o beneficio de tratamiento médico que le haya proporcionado su empleador o State Fund. Es importante actuar rápidamente para no correr el riesgo de perder los beneficios por demorarse demasiado.

Derecho a recibir atención médica. Usted tiene derecho a recibir atención médica, a cargo de su empleador, para reponerse de una lesión o enfermedad laboral. Hasta tanto se acepte o rechace el reclamo, la legislación vigente obliga al empleador a autorizar tratamiento médico por un valor máximo de \$10,000 en total dentro de las 24 horas posteriores a la presentación del formulario de reclamos, conforme a las disposiciones y limitaciones de la legislación. La atención médica puede incluir gastos para médicos, servicios hospitalarios, terapia física, pruebas de laboratorio, radiografías, medicamentos y transporte relacionado. En el caso de lesiones posteriores al 1ro de enero de 2004, existen restricciones en la cantidad de sesiones de terapia ocupacional, física y quiropráctica. Dichas restricciones no se aplican a sesiones después de una cirugía cuando están basadas en un programa de utilización postquirúrgica establecida por el director administrativo (AD). Todo tratamiento médico se realiza conforme a su correspondiente programa de utilización.

¿Qué es la State Fund Medical Provider Network (Red de Proveedores Médicos de State Fund)? Usted debería haber recibido la información relacionada a la State Fund Medical Provider Network (MPN) de su empleador en el momento en que se le contrató o cuando su empleador implementó la MPN.

La State Fund MPN es una red selecta de médicos y otros proveedores de servicios médicos para proveer tratamiento a los trabajadores lesionados en el trabajo. Se debería publicar un folleto del State Fund MPN cerca de este póster el cual explicará cómo utilizar la MPN. Usted puede pedir una copia de este folleto al llamar al (888) 222-3211 o al descargar el folleto del sitio web de State Fund en www.statefundca.com.

¿Cuál es la función del médico tratante? El médico tratante decide qué tipo de atención médica necesita para reponerse de su lesión o enfermedad, determina cuándo podrá regresar al trabajo, ayuda a determinar qué tipos de trabajo puede realizar sin riesgos durante su recuperación, lo deriva a los especialistas correspondientes (en caso de ser necesario) y redacta informes médicos que tienen influencia sobre los beneficios que recibe.

Si usted tiene un médico personal designado antes de su lesión en el trabajo, entonces usted podrá recibir tratamiento de su médico previamente designado.

El médico previamente designado debe cumplir con los siguientes requisitos:

- Debe ser su médico de cabecera.
- Debe ser su médico de atención primaria o el grupo médico de multiespecialidades del médico.
- Debe tener licencia conforme al Código de Negocios y Profesiones.
- Debe haberlo tratado previamente.
- Debe conservar sus registros médicos, incluida la historia clínica.
- Está de acuerdo en ser su médico previamente designado.

Para designar previamente un médico, usted debe darle a su empleador el nombre y dirección de su médico personal o su grupo personal de doctores de multiespecialidades médicas por escrito, antes de sufrir una lesión.

Si no designa previamente ningún médico, su empleador elegirá un médico de la MPN para su tratamiento inicial. Luego de este tratamiento inicial, usted podrá elegir un médico de la MPN.

Si usted se lesionó y está recibiendo tratamiento de un médico que no está en la MPN, y usted no había designado uno previamente, puede que se le pida que se cambie con un médico dentro de la MPN.

ADVERTENCIA: La ley prohíbe presentar un reclamo fraudulento de compensación a los trabajadores o realizar una declaración falsa o fraudulenta (en forma oral o escrita) a favor o en contra de un reclamo de compensación a los trabajadores, así como profetizar o conspirar con un tercero para cometer el mismo fraude. Los culpables de tales delitos serán castigados con 5 años de prisión como máximo o con una multa de \$100,000 o el doble del valor del fraude (el monto que sea mayor) o bien, serán sancionados con ambas penas (prisión y multa). También pueden corresponder indemnizaciones y otras sanciones.

Este aviso, que cumple con la Sección 3550 del Código Laboral, cuenta con la aprobación del director administrativo del Division of Workers' Compensation (DWC).

13709 (Rev. 09/10)

©2010 State Compensation Insurance Fund

City of Long Beach / TSE WORKERS ONLY Long Beach Medical Clinic 1250 Pacific Ave. Long Beach, CA 90813 (562) 437-0837

Nuestra compañía de seguros de compensación a los trabajadores es:

STATE COMPENSATION INSURANCE FUND
CENTRO DE ATENCIÓN DE RECLAMOS LAS 24 HORAS
(888) 222-3211 línea gratuita

¿Puedo designar previamente a un quiropráctico o acupunturista? No. Sin embargo, si la MPN no correspondiera por algún motivo y usted hubiera elegido por escrito un quiropráctico o acupunturista personal con anterioridad a la fecha de la lesión, podrá solicitar que sustituyan al médico elegido por su empleador por el quiropráctico o acupunturista de su elección.

El cambio de médico se puede solicitar en cualquier momento después del tratamiento inicial provisto por su empleador.

Para obtener más información, comuníquese con su empleador, con la compañía de seguros de compensación a los trabajadores de su empleador o con el administrador de reclamos.

Beneficios por discapacidad. Si es hospitalizado o no puede trabajar por un lapso mayor a tres días, usted recibirá beneficios por discapacidad temporal (TD), equivalente a dos tercios de la remuneración semanal media hasta el límite máximo semanal impuesto por la ley. En caso de lesiones con fecha del 1ro de enero de 2008 o después, el TD no se pagará después de 104 semanas indemnizables dentro de un período de cinco años posteriores al pago inicial de dicho beneficio. Quedan exceptuadas ciertas lesiones que demoran más tiempo en curarse. El límite máximo en estos casos es de 240 semanas dentro de un período de cinco años. Si la lesión le provocara una discapacidad permanente que disminuyera su capacidad de trabajo, recibirá pagos adicionales.

Beneficios en caso de muerte. En caso de muerte por lesión en el trabajo, las personas a su cargo recibirán un beneficio.

Beneficio Complementario por Beneficios de Cambio de Trabajo. En el caso de lesiones posteriores al 1 de enero de 2004, se otorgará un vale no transferible pagadero a una escuela con aprobación estatal si su lesión resulta en una incapacidad permanente, y previene que regrese a trabajar dentro de 60 después que se termine su TD, y su empleador no le ofrezca un trabajo modificado o alternativo.

Discriminación. Según la legislación vigente, es ilegal que su empleador lo sancione o despidan por tener una lesión o enfermedad, por presentar un reclamo o por prestar declaración en un caso de compensación a los trabajadores de un tercero. En caso de comprobarse alguna de estas infracciones, usted podrá recibir los salarios perdidos, la reincorporación al trabajo, beneficios adicionales y los costos y gastos hasta los límites establecidos por el estado.

Un funcionario de información y asesoramiento del Division of Workers' Compensation (DWC) le suministrará la información y los formularios necesarios para resolver los problemas que pudieran surgir al realizar el reclamo. Puede comunicarse con el funcionario más cercano a su domicilio o lugar de trabajo de la siguiente manera:

Lugar _____

Número telefónico gratuito (800) 736-7401.
Sitio web: www.dwc.ca.gov o www.dir.ca.gov/dlse

El empleador puede quedar exento del pago de los beneficios de compensación a los trabajadores en el caso de lesiones que se produjeran por la participación voluntaria del empleado en actividades recreativas, sociales o deportivas fuera del horario laboral que no formasen parte de las tareas de su trabajo.

Medical Provider Network. Para obtener la lista de los proveedores de State Fund en su área, llame a la línea gratuita del Claims Reporting Center: (888) 222-3211 o usted puede escribirnos a:

State Compensation Insurance Fund.
Attn: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

También se encuentra disponible un directorio regional de los proveedores médicos de State Fund en MEDfinder en www.statefundca.com o enviando un correo electrónico a scifmpn@scif.com.

Fecha Efectiva de la MPN: _____

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	STATE COMPENSATION INSURANCE FUND 24-Hour Claims Reporting Center Telephone: (888) 222-3211 Fax (800) 371-5905	OSHA Case No. <input type="checkbox"/> Fatality
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Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

E M P L O Y E R	1. FIRM NAME CalWORKs/Work Experience-Southbay Work	DIVISION Force Invest. Board	1a. Policy Number 00000-CONTRG -0	Please do not use this Column Case Number	
	2. MAILING ADDRESS (Number and Street, City, Zip) CMS-San Bernardino P.O Box 65005 Pinedale CA, 93650-5005	2a. Phone Number 310-970-7796			
	3. LOCATION, if different from Mailing Address (Number, Street, City and Zip) 11539 Hawthorne Blvd. Ste. 500 Hawthorne, CA 90250	3a. Location Code 190		Ownership	
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc. Employment Development	5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.		Industry	
	6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <input checked="" type="checkbox"/> OTHER GOVERNMENT - SPECIFY State Contract/Nonprofit				Occupation

I N J U R Y O R I L L N E S S	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	Sex	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. DATE LAST WORKED (mm/dd/yy)	13. DATE RETURNED TO WORK (mm/dd/yy)	14. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	Age	
	15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO	16. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)	Daily hours	
	19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.				19a. BODY PART AFFECTED	Days per Week
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)	20a. ZIP	20b. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	21a. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Hours
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.			23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		Weekly Wage
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.					
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.					County
	26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.					Nature of Injury
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)				27a. Phone Number	
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)				28a. Phone Number	Part of body	
				29. Employee treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO		

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

E M P L O Y E E	30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	Source		
	33. HOME ADDRESS (Number, Street, City, Zip)			33a. PHONE NUMBER		Event	
	34. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)			36. DATE OF HIRE (mm/dd/yy)	Secondary Source	
	37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week 32-40 total weekly hours		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> retired <input type="checkbox"/> unemployed <input checked="" type="checkbox"/> temporary <input type="checkbox"/> seasonal <input type="checkbox"/> laid-off <input type="checkbox"/> other		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?		Extent of Injury
	38. GROSS WAGES/SALARY \$ 8.00 per hr.		39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO				

40. Number of employees on most recent policy inception or renewal date in effect at time of injury.		Date (mm/dd/yy)
Completed By (type or print)	Signature & Title	

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.



WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información grabada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee—complete this section and see note above Empleado—complete esta sección y note la notación arriba.

1. Name, *Nombre*. _____ Today's Date, *Fecha de Hoy*. _____
2. Home Address, *Dirección Residencial*. _____
3. City, *Ciudad*. _____ State, *Estado*. _____ Zip, *Código Postal*. _____
4. Date of Injury, *Fecha de la lesión (accidente)*. _____ Time of Injury, *Hora en que ocurrió*. _____ a.m. _____ p.m.
5. Address and description of where injury happened, *Dirección/lugar dónde ocurrió el accidente*. _____
6. Describe injury and part of body affected, *Describe la lesión y parte del cuerpo afectada*. _____
7. Social Security Number, *Número de Seguro Social del Empleado*. _____
8. Signature of employee, *Firma del empleado*. _____

Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.

9. Name of employer, *Nombre del empleador*. CalWORKs -Work Exp. / Southbay Workforce Investment Board (SBWIB)
10. Address, *Dirección*. 11539 Hawthorne Blvd., Ste. 500 Hawthorne, CA 90250
11. Date employer first knew of injury, *Fecha en que el empleador supo por primera vez de la lesión o accidente*. _____
12. Date claim form was provided to employee, *Fecha en que se le entregó al empleado la petición*. _____
13. Date employer received claim form, *Fecha en que el empleado devolvió la petición al empleador*. _____
14. Name and address of insurance carrier or adjusting agency, *Nombre y dirección de la compañía de seguros o agencia administradora de seguros*.
State Compensation Insurance Fund
15. Insurance Policy Number, *El número de la póliza de Seguro*. 000000-CONTRG-0
16. Signature of employer representative, *Firma del representante del empleador*. _____
17. Title, *Título*. EDA 18. Telephone, *Teléfono*. (310) 970-7796

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

- Employer copy/Copia del Empleador Employee copy/Copia del Empleado Claims Administrator/Administrador de Reclamos Temporary Receipt/Recibo del Empleado

South Bay Workforce Investment Board – GAIN Unit

STATEMENT OF DECLINE

I, _____, have been offered medical treatment for the incident /accident that occurred on _____ at the _____.

I do not feel I need medical attention at this time so I have willfully declined any further treatment offered by South Bay Workforce Investment Board – City of Hawthorne’s State Compensation Insurance Fund.

Print Name

Date

Signature

Date

Witness (Print Name)

Date

Witness (Signature)

Date

NOTICE TO EMPLOYEES

Your employer has included Greater Avenues for Independence (GAIN) program participants in the workforce at this location. State law prohibits employers from using GAIN participants in a way that will cause other employees to lose their job, to be laid off, or to have their work hours reduced, including overtime hours currently being worked. An employer cannot place GAIN participants into jobs which would otherwise be promotional opportunities for existing employees, or into vacant positions which are not newly created jobs. Finally, an employer must not violate any personnel rules when including a GAIN participant in the workforce.

If you believe your employer has violated any of the rules discussed above and this has led to problems with your job, you may speak to your office administrator who will try to resolve this problem.

If the problem cannot be resolved and you are covered by a bargaining agreement with a labor union, follow the grievance procedures outlined in your memorandum of understanding.

If the problem cannot be resolved, and you are not covered by a bargaining agreement with a labor union, follow the grievance procedures outlined below:

A complaint against your employer must be in writing and must contain the following information:

- **Your full name, your address (if you have one) and your telephone number (if you have one);**
- **The full name and address of your employer;**
- **A clear and brief statement of the facts, including important dates, which have led you to file this complaint; and**
- **A statement that this complaint has been filed under penalty of perjury.**
- **Send the complaint to:**

**City of Hawthorne
SBWIB/GAIN Unit
11539 Hawthorne Blvd., Ste. 500
Hawthorne, CA 90250
Attention: Tracey Atkins, GAIN Program Manager**

**LOS ANGELES COUNTY
GREATER AVENUES FOR
INDEPENDENCE
(GAIN)**

**Transitional Subsidized Employment
Program (TSE)/Work Experience (WEX)**

SUPERVISOR'S HANDBOOK



11.30.11

REFERRAL/ENROLLMENT PROCEDURES

WHEN YOUR AGENCY'S NAME IS SELECTED FROM THE LOS ANGELES COUNTY INVENTORY OF **Transitional Subsidized Employment Program (TSE) / Work Experience (WEX)** PROVIDERS:

- A. A Worksource Center Representative (**WCR**) will telephone your agency to introduce the GAIN Participant and set an appointment for an interview.
- B. The Participant will come to your agency with a **COUNTY OF LOS ANGELES PROVIDER REFERRAL (GN 6006)**.
- C. After being interviewed and accepted by the worksite agency, the Participant's supervisor completes a **JOB SPECIFICATION SHEET (Attachment A)** that outlines the GAIN Participant's duties and responsibilities. The Supervisor gives one (1) copy to the GAIN Participant and retains one (1) copy for the Participant file.

TO COMPLETE THE ENROLLMENT PROCESS: A copy of the **GN 6006** with Section B completed by the worksite supervisor and must be returned to the **WCR** within **8 working days**.

FILE SUMMARY SET-UP

A FILE MUST BE SET-UP & MAINTAINED FOR EACH TSE/WEX Participant. All TSE/WEX PARTICIPANT FILES MUST CONTAIN THE FOLLOWING:

- A. Copy of the GN 6006 with Section B completed by the Worksite Supervisor.
- B. Copy of the TSE/WEX JOB SPECIFICATION SHEET (ATTACHMENT A).
- C. TSE/WEX PROGRAM SIGN-IN/SIGN-OUT SHEET (ATTACHMENT B).
- D. All TSE Participants must sign a GAIN Participant Acknowledgment and Confidentiality Agreement (ATTACHMENT C).
- E. Contractor Supervisor Acknowledgment and Confidentiality Agreement (ATTACHMENT D).
- F. A GN 6070 PROGRESS REPORT (required if Participant has attended more than 3 months).
- G. Occasionally you may receive a NOTIFICATION OF CHANGE (GN 6007B) which changes the number of hours or status of a Participant. A copy should be kept in the Participant's file.

FILES MUST BE MAINTAINED FOR EACH PARTICIPANT FOR A PERIOD OF FIVE YEARS FOLLOWING THE TERMINATION OF THE CONTRACT, OR UNTIL FEDERAL, STATE, COUNTY AND CONTRACTOR AUDITS ARE COMPLETED, WHICHEVER IS LATER. FILES MUST BE MADE AVAILABLE TO ALL AUTHORIZED FEDERAL, STATE (INCLUDING THE AUDITOR GENERAL), COUNTY AND INTERMEDIARY PERSONNEL UPON REQUEST.

NOTE: Attachments A, B, C, and D should be copied for future use.

IMPORTANT THINGS TO REMEMBER **

1. The supervisor shall assist and encourage qualified **TSE/WEX** Participants to compete for job openings within the worksite provider's organization.
2. The supervisor will not allow TSE/WEX Participants to perform nor be permitted to perform any partisan political activities or be utilized in any activities in support for or against the election of any candidate for public office, nor allow or permit the Participant to perform in any religious activities.
3. Worker's Compensation Insurance for TSE/WEX Participants is maintained by a State policy. In the event of an injury to a TSE/WEX Participant, the supervisor must notify the **Intermediary Contractor** within 24 hours of an incident at **(310) 970-7796** for further instructions. The supervisor must complete the **State of California Insurance Forms SCIF 3367** and **SCIF 3301**.

In the event of serious injury or death, the supervisor is also to notify **Celeste Sibal** at **(562) 908-5727** within 24 hours.

4. For questions about your agency's responsibilities in providing GAIN TSE/WEX assignments, contact **Tracey Atkins, GAIN Manager, City of Hawthorne, (310) 970-7796**.

**** For a full description of requirements and restrictions, please refer to your agency's non-financial subcontract agreement.**

ATTACHMENT A

TSE/WEX PROGRAM JOB SPECIFICATION SHEET

Worksite Provider: _____

Department: _____

Participant's Name: _____

Type of Assignment: TSE _____ WEX _____

Number of Hours Assigned per Week: _____

Job Title: _____

Job Duties/Responsibilities:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Equipment/Materials to be used:

ATTACHMENT B

TSE/WEX PROGRAM SIGN-IN/SIGN-OUT SHEET

Participant's Name _____

Worksite Name _____

DATE	TIME IN	TIME OUT	TOTAL HOURS	REASON FOR LOST TIME

SUPERVISOR'S SIGNATURE _____

PARTICIPANT'S SIGNATURE _____

**ATTACHMENT C
TSE/WEX PARTICIPANT
ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT**

GENERAL INFORMATION:

Your Transitional Subsidized Employment Program (TSE)/Work Experience (WEX) provider, e _____, has entered into an agreement with the City of Hawthorne's Job Training and Development Department (hereinafter referred to as the "Intermediary Contractor") to provide various services to the Intermediary Contractor and the County of Los Angeles. As a result, your signature is required on this Subcontractor Employee Acknowledgment and Confidentiality Agreement.

PARTICIPANT ACKNOWLEDGMENT

I understand that _____ is my sole TSE/WEX provider for purposes of this training.

I rely exclusively upon GAIN/CalWORKs for payment of salary and any and all other benefits payable to me or on my behalf during the period of this TSE/WEX training.

I understand and agree that I am not an employee of the INTERMEDIARY CONTRACTOR or of Los Angeles County for any purposes and that I do not have and will not acquire any rights or benefits of any kind from the INTERMEDIARY CONTRACTOR or the County of Los Angeles during the period of this TSE/WEX training.

I understand and agree that I do not have nor will I acquire any rights or benefits pursuant to any agreement between my TSE/WEX training provider, _____ and the INTERMEDIARY CONTRACTOR or the County of Los Angeles.

CONFIDENTIALITY AGREEMENT

As a GAIN TSE/WEX Participant of _____ you may be involved with work pertaining to County Services and if so, you may have access to confidential data pertaining to persons and or other entities who receive services from the County of Los Angeles. The County of Los Angeles and all of its contractors and subcontractors have a legal obligation to protect all confidential data, especially data concerning welfare recipient records. Since you may be involved with work with welfare recipients, the County must ensure that you, too, will protect the confidentiality of data. You must sign this confidentiality agreement as a condition of your work assignment to be provided to _____ for the County of Los Angeles and/or the Intermediary Contractor.

Please read the GAIN Participant Acknowledgment and Confidentiality Agreement carefully and take your time to consider it before signing.

I hereby agree that I will not divulge to any unauthorized personal data obtained while assigned at this work site pursuant to the agreement between _____ and the INTERMEDIARY CONTRACTOR or the County of Los Angeles.

I agree to report any and all violations of the above by any other person and/or by myself to any immediate supervisor and I agree to ensure that said supervisor reports such violation to the County of Los Angeles Department of Public Social Services. I agree to return all confidential materials to my immediate supervisor upon termination of my TSE/WEX training with _____ or completion of the presently assigned work tasks, whichever occurs first.

I acknowledge that violation of this acknowledgment and agreement may subject me to civil and/or criminal action and that the County of Los Angeles will seek all possible legal redress.

GAIN PARTICIPANT:

Signature: _____ **Date:** _____

Print-Name: _____ **Date:** _____

Attachment D

**SUBCONTRACTOR EMPLOYEE (*Worksite Supervisor*)
ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT**

GENERAL INFORMATION

The City of Hawthorne on behalf of the South Bay Workforce Investment Board, hereinafter referred to as SBWIB, has entered into a contract with the County of Los Angeles hereafter known as COUNTY to provide services for participants in the Greater Avenue for Independence (GAIN) Program. As part of your employment you may be involved with work pertaining to COUNTY services and have access to confidential data pertaining to persons and/or other entities who receive services from SBWIB and COUNTY, which have a legal obligation to protect all such data, including welfare recipient records.

If you are to be involved in such work, the SBWIB and COUNTY must ensure that you will protect the confidentiality of all data and require that you sign this confidentiality agreement.

EMPLOYEE ACKNOWLEDGEMENT

I understand and agree that my employer is my sole employer for purposes of employment. I rely exclusively upon it for payment of salary and any and all other benefits payable to me or on my behalf during the period of my employment. I am not an employee of the COUNTY or SBWIB for any purpose. I do not have and will not acquire any rights or benefits of any kind from COUNTY or SBWIB during the period of my employment, and do not have, and will not acquire, any rights or benefits pursuant to any agreement between SBWIB and COUNTY.

CONFIDENTIALITY REPORT

I hereby agree that I will not divulge to any unauthorized person, data obtained while performing work pursuant to the contract between SBWIB and COUNTY. I will forward all requests for the release of information received by me to my immediate supervisor, or report such violation to SBWIB and COUNTY, and return all confidential materials to my immediate supervisor upon termination of my employment or completion of the presently assigned work tasks, whichever occurs first.

I understand that a violation of this agreement and acknowledgement may subject me to civil and/or criminal action and that COUNTY or SBWIB may seek all possible legal redress.

Name: _____
(Signature)

Name: _____
(Print)

Date: _____

Position: _____
(Print)