

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**CWEP INDIVIDUAL PARTICIPATION AGREEMENT**

**I. IDENTIFYING INFORMATION:**

Name: \_\_\_\_\_ WV DHHR Office: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
 \_\_\_\_\_ CWEP Contract No.: \_\_\_\_\_  
 Social Security No.: \_\_\_\_\_ PII No.: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_ Worker: \_\_\_\_\_

**II. PARTICIPANT INSTRUCTIONS:**

I understand that I am being placed in the Community Work Experience Program (CWEP), which is a non-salaried work/training experience placement. I agree to participate the number of hours indicated below. Should my hours of participation change, this Agreement may be changed.

I understand that I must report any absence to the **Contractor** in accordance with **Contractor's** rules and regulations; must participate the total number of hours each month. Any day missed, that is not excused, must be made up in the same month. Absence for a job interview or an appointment with Department staff must be pre-approved. Routine appointments for other reasons must be scheduled on non-participation days or during non-participation hours, except for an emergency. If I am going to be absent for any reason I must contact my supervisor immediately.

I understand my participant status will be re-evaluated in six (6) months or earlier if appropriate.

I understand that I will receive **transportation reimbursement**. The mileage is \_\_\_\_\_ miles **round trip**, and my expense allowance is \$\_\_\_\_\_ per day. I must notify my case worker of any change in residence or participation site location.

I understand that a failure/refusal to cooperate with this program may result in the loss of cash assistance benefits and Food Stamp benefits.

I understand that at any time I may request a **conference** or fair hearing with Department staff regarding issues related to my participation in CWEP. I further understand I have the right to have my complaints concerning CWEP on the participation site working conditions and my participation determination reviewed through a Grievance Process.

Beginning Date/Time: \_\_\_\_\_  
 Contractor: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
 Location: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
 Occupational Title: \_\_\_\_\_ Monthly Participation Hours: \_\_\_\_\_

Participant's Signature/Date

Case Worker's Signature/Date

**III. CONTRACTOR INSTRUCTIONS**

The number of hours for this participant will be \_\_\_\_ each month. You must schedule participation hours in full days, if possible, in order to keep transportation costs of participant low, keeping in mind the necessary flexibility to allow the participant to meet other requirements placed on him by the Department. A daily split shift is not permissible unless requested by the participant. You must also develop a mutually agreed upon written monthly work schedule with the participant. Notify the case worker above, on the first day that the participant reports to the participation site.

Specific Information: \_\_\_\_\_

DISTRIBUTION (TRIPLICATE): (1) **Contractor** (2) Department Case Record (3) Participant