Department of Health and Social Services
Division of Public Assistance
ALASKA TEMPORARY ASSISTANCE PROGRAM
Community Work Experience Placement Agreement

Participant's name:	
DPA office address:	Work site name and address:
Work site phone number:	Name of work site supervisor:
Start date:	End date:
List work site tasks assigned to the participant:	
Number of hours per week:	Work schedule (days/times):

Participant's responsibilities:

- arrive promptly for work
- treat this work experience like a job
- ask your supervisor for help if you need it
- notify your supervisor, DPA caseworker or representative, and child care provider if you cannot be at work as scheduled.

I understand that dismissal from the work site because of poor attendance, poor performance, or for acts which endanger myself or others may result in my family's loss or reduction of Temporary Assistance benefits and Food Stamps.

_____ _____
Participant Date

_____ _____
Caseworker (DPA or its agent) Date

The Alaska Department of Health and Social Services, Division of Public Assistance, complies with Title II of the Americans with Disabilities Act of 1990. This form is available in alternative communication format upon request. Please contact the Director's Special Assistant at (907) 465-3349, TDD (907) 465-3347.

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ORIGINAL - PARTICIPANT COPY - WORKSITE COPY – CASE RECORD