Massachusetts Department of Transitional Assistance
Full Employment Program Enrollment/Agreement

CAN

Local Office Address

Name (Please Print)

Social Security Number

I wish to enroll in the Full Employment Program. I understand that by enrolling in the Full Employment Program and agreeing to the following conditions, I will:

- be employed full-time,
- receive a pay check instead of my cash assistance and food stamps (if I received food stamps),
- have to report monthly, on a form prescribed by the Department, my earnings and/or any other changes in my family's circumstances,
- be eligible for a cash supplement if my wages do not equal the value of the cash assistance and food stamps that I otherwise am eligible to receive (amount will be calculated every month),
- continue to receive Medical Assistance for myself and my family members,
- be eligible to receive child care services if needed,
- be responsible to pay any bills that had been paid by vendor payment while I was receiving cash assistance,
- continue to repay any overpayment I owe the Department,
- get the money from an individual asset account at the end of my Full Employment Program participation,
- be eligible for Transitional Child Care (TCC) and Transitional Medical Assistance (TMA) when my Transitional Aid to Families with Dependent Children case closes due to my earnings, and
- get direct payment of all child support when my Transitional Aid to Families with Dependent Children case closes.

By signing this enrollment/agreement, I understand and agree to the above conditions for my participation in the Full Employment Program.

Signature of Recipient

____/____/____
Date

Signature of Worker

____/____/____
Date