

# GENERAL ASSISTANCE STATEMENT OF FACTS

Fill in the answers to all questions print all answers in ink. Give any proof (such as bills, receipts, check stubs, etc.) to support your answers.

|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | County Use Only                                                                                                                                                                                                                                                                                                                           |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1</b>  | <div>Applicant (Full Name)</div> <div>Spouse/Domestic Partner (Full Name)</div> <div>Home Address</div> <div>City/ Zip Code</div> <div>SSN - -</div> <div>Birth date / /</div> <div>Birth Place</div>                                                                                                                                                                                                                                                                                                              | <div>Home/Message Phone</div> <div>Case Name</div> <div>Mailing address</div> <div>Case Number</div> <div>City/ Zip Code</div> <div>Technician</div> <div>Date Rec'd</div>                                                                                                                                                                |
|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Case Comments and Verifications</b>                                                                                                                                                                                                                                                                                                    |
| <b>2</b>  | <div>Are you, your spouse, or your domestic partner able to work? You <input type="checkbox"/> Yes <input type="checkbox"/> No Your Spouse/Domestic Partner <input type="checkbox"/> Yes <input type="checkbox"/> No If No for either person, give a reason</div> <div><input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated</div>                                                         | <input type="checkbox"/> B/C <input type="checkbox"/> ID <input type="checkbox"/> SSN<br><input type="checkbox"/> INS DOC #<br><input type="checkbox"/> KCDHS 111 ISSUED _____<br><input type="checkbox"/> KCDHS 110 SENT _____<br><input type="checkbox"/> KCDHS 142<br><input type="checkbox"/> FR 30<br><input type="checkbox"/> CW 22 |
| <b>3</b>  | <div><input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Parolee</div> <div><input type="checkbox"/> Lawful Permanent Resident <input type="checkbox"/> Sponsored</div>                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL                                                                                                                                                                                                                                                                         |
| <b>4</b>  | <div>Are you, your spouse, or your domestic partner currently under doctor's care? You <input type="checkbox"/> Yes <input type="checkbox"/> No Your Spouse/Domestic Partner <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>Doctors name/address:</div>                                                                                                                                                                                                                                       | <input type="checkbox"/> EMPLOYABLE<br><input type="checkbox"/> DISABLED                                                                                                                                                                                                                                                                  |
| <b>5</b>  | <div>Are you, your spouse, or domestic partner currently applying for or receiving?</div> <div>CalFresh <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If yes, where? _____ Cal-WORKS? <input type="checkbox"/> Yes <input type="checkbox"/> No</div>                                                                                                                                                           | <div>PRIOR SUPPORT</div> <div>_____</div> <div>_____</div> <div>_____</div> <div>_____</div>                                                                                                                                                                                                                                              |
| <b>6</b>  | <div>Have you, your spouse, or domestic partner ever used any other name (maiden, adoptive, alias, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If yes, please list below:</div> <div>_____</div> <div>_____</div>                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                           |
| <b>7</b>  | <div>Do you, your spouse/domestic partner live in Kern County? <input type="checkbox"/> Yes How Long? _____ <input type="checkbox"/> No</div> <div>Where did you, your spouse/domestic partner live prior to moving to Kern County?</div> <div><input type="checkbox"/> You, County _____ How Long _____</div> <div><input type="checkbox"/> Your Spouse/Domestic Partner County _____ How long _____</div> <div>If you lived in more than two counties, list which person, what county, and how long below:</div> | <input type="checkbox"/> 15 DAY RESIDENCY DATE ESTABLISHED _____<br><br><input type="checkbox"/> OTHER COUNTY(S) RESPONSIBLE FOR GA COSTS _____                                                                                                                                                                                           |
| <b>8</b>  | <div>Do you, your spouse/domestic partner plan to stay in Kern County? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If "No", explain:</div>                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> VERIFICATION ON FILE                                                                                                                                                                                                                                                                                             |
| <b>9</b>  | <div>Do you, your spouse, or domestic partner own or are you buying a home or other property? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete below:</div> <div>Address/Location _____</div> <div>Owner _____</div>                                                                                                                                                                                                                                                                    | <input type="checkbox"/> VERIFIED SANCTION ENDS                                                                                                                                                                                                                                                                                           |
| <b>10</b> | <div>Has yours, your spouse's or domestic partner's General Assistance or CalWORKs benefits been stopped due to sanction, non-cooperation or any other reason? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", explain below:</div>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                           |
| <b>11</b> | <div>Is any member in the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", who:</div>                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                           |

| <b>12</b>                      | Do you live in any of the following: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "Yes", complete below:<br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> shelter, center<br/> <input type="checkbox"/> drug or alcohol rehabilitation center<br/> <input type="checkbox"/> group living arrangement/home         </div> <div> <input type="checkbox"/> hospital or nursing home<br/> <input type="checkbox"/> subsidized housing<br/> <input type="checkbox"/> board and care home<br/> <input type="checkbox"/> homeless         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Case Comments and Verifications</b><br><hr/> GA ELIGIBLE SANCTION ENDS<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                         |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
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|                                | <div style="display: flex; justify-content: space-between;"> <div>Name of facility</div> <div>Date entered</div> <div>Name of program</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>13</b>                      | What is the highest grade you, your spouse/domestic partner completed in school? You _____ GED<br><input type="checkbox"/> Yes <input type="checkbox"/> No Degree: <input type="checkbox"/> Yes Type: _____ <input type="checkbox"/> No<br>Your spouse/domestic partner? _____ GED <input type="checkbox"/> Yes <input type="checkbox"/> No Degree? <input type="checkbox"/> Yes Type: _____ <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>14</b>                      | Is anyone enrolled in any of the following: <input type="checkbox"/> Yes If "Yes", complete below: <input type="checkbox"/> No<br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Training program<br/> <input type="checkbox"/> School         </div> <div> <input type="checkbox"/> Vocational Rehabilitation program<br/> <input type="checkbox"/> College         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> VERIFIED                                                                                                                                                                                                             |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | Name of School, college or training program                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>15</b>                      | Have you, your spouse, or domestic partner ever been in the U.S. Military Service"? <input type="checkbox"/><br>Yes <input type="checkbox"/> No<br>If "Yes", branch of service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> CA 5 ON FILE<br><br><input type="checkbox"/> VERIFICATION ON FILE                                                                                                                                                    |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>16</b>                      | Are you, your spouse or domestic partner working now or expect to be working in the next 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", explain below:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | <div style="display: flex; justify-content: space-between;"> <div>Name</div> <div>Employer Name</div> <div>Occupation</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | <div style="display: flex; justify-content: space-between;"> <div>Days/hours worked per month</div> <div>Pay Dates</div> <div>Wages (gross)</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>17</b>                      | Have you, your spouse, or domestic partner stopped or refused work or training within the last 30 days?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete below:<br>Employer name/address/phone number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> GOOD CAUSE<br><input type="checkbox"/> SANCTIONED FROM _____ TO _____<br><input type="checkbox"/> VOLUNTARY QUIT                                                                                                     |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | <div style="display: flex; justify-content: space-between;"> <div>Last day worked:</div> <div>Last paycheck received:</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | <div style="display: flex; justify-content: space-between;"> <div>Expect check (date):</div> <div>Reason for leaving:</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>18</b>                      | Are you, your spouse, or your domestic partner on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No Date went on strike?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| <b>19</b>                      | Have you, your spouse, or domestic partner applied for/are receiving money from any source?<br>Check <b>Yes</b> or <b>No</b> for each source.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | APPLICATION FOR UNCONDITIONALLY AVAILABLE INCOME:<br><input type="checkbox"/> UBI-DATE:<br><input type="checkbox"/> SDI-DATE:<br><input type="checkbox"/> RSDI- DATE:<br><input type="checkbox"/> SSI-DATE:<br><input type="checkbox"/> OTHER |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Unemployment Insurance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>State Disability Insurance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Social Security Benefits</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Veterans Administration</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>SSI/SSP</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Workers Compensation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>School Grants/Loans</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Railroad Retirement</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Training Benefits</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Pensions or Disability</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Military allotment/Pension</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Spousal Support</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Legal or Insurance Settlements</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Strike Benefits</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Other (explain)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> |                                                                                                                                                                                                                                               | Yes                        | No                       |                          | Yes | No | Unemployment Insurance | <input type="checkbox"/> | <input type="checkbox"/> | State Disability Insurance | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Benefits | <input type="checkbox"/> | <input type="checkbox"/> | Veterans Administration | <input type="checkbox"/> | <input type="checkbox"/> | SSI/SSP | <input type="checkbox"/> | <input type="checkbox"/> | Workers Compensation | <input type="checkbox"/> | <input type="checkbox"/> | School Grants/Loans | <input type="checkbox"/> | <input type="checkbox"/> | Railroad Retirement | <input type="checkbox"/> | <input type="checkbox"/> | Training Benefits | <input type="checkbox"/> | <input type="checkbox"/> | Pensions or Disability | <input type="checkbox"/> | <input type="checkbox"/> | Military allotment/Pension | <input type="checkbox"/> | <input type="checkbox"/> | Spousal Support | <input type="checkbox"/> | <input type="checkbox"/> | Legal or Insurance Settlements | <input type="checkbox"/> | <input type="checkbox"/> | Strike Benefits | <input type="checkbox"/> | <input type="checkbox"/> |  |  |  | Other (explain) | <input type="checkbox"/> | <input type="checkbox"/> |  |
|                                | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | No                                                                                                                                                                                                                                            |                            | Yes                      | No                       |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| Unemployment Insurance         | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | State Disability Insurance | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| Social Security Benefits       | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | Veterans Administration    | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| SSI/SSP                        | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | Workers Compensation       | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| School Grants/Loans            | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | Railroad Retirement        | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| Training Benefits              | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | Pensions or Disability     | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| Military allotment/Pension     | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | Spousal Support            | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
| Legal or Insurance Settlements | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                                                                                                                                                                                      | Strike Benefits            | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                               | Other (explain)            | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | If "Yes", complete below:<br><div style="display: flex; justify-content: space-between;"> <div>Who</div> <div>What</div> <div>Gross Amount</div> <div>Dates Received</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | \$                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                | \$                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                               |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <hr/> DATE<br><br><input type="checkbox"/> SSI APPEAL PENDING<br><input type="checkbox"/> REFERRAL TO SSI ADVOCATE                                                                                                                            |                            |                          |                          |     |    |                        |                          |                          |                            |                          |                          |                          |                          |                          |                         |                          |                          |         |                          |                          |                      |                          |                          |                     |                          |                          |                     |                          |                          |                   |                          |                          |                        |                          |                          |                            |                          |                          |                 |                          |                          |                                |                          |                          |                 |                          |                          |  |  |  |                 |                          |                          |  |

|                            |                                                                                                                                                                                                                                                                                                                     |                          |                                               | CASE COMMENTS AND VERIFICATIONS   |                                                       |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------|-----------------------------------|-------------------------------------------------------|
| <b>20</b>                  | Do you, your spouse, or domestic partner have a settlement pending? <input type="checkbox"/>                                                                                                                                                                                                                        |                          |                                               |                                   |                                                       |
|                            | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                            |                          |                                               |                                   |                                                       |
|                            | Do you have an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                          |                          |                                               |                                   |                                                       |
|                            | If Yes, explain, complete below:                                                                                                                                                                                                                                                                                    |                          |                                               |                                   |                                                       |
|                            | Attorney name/address:                                                                                                                                                                                                                                                                                              |                          |                                               |                                   |                                                       |
|                            | Company/person suing:                                                                                                                                                                                                                                                                                               |                          |                                               |                                   |                                                       |
|                            | Insurance Company                                                                                                                                                                                                                                                                                                   |                          |                                               |                                   |                                                       |
| Date of accident or injury |                                                                                                                                                                                                                                                                                                                     |                          | <input type="checkbox"/> WORKERS COMP.        |                                   |                                                       |
| Reason:                    |                                                                                                                                                                                                                                                                                                                     |                          | <input type="checkbox"/> VERIFIED             |                                   |                                                       |
| <b>21</b>                  | Have you, your spouse or your domestic partner sold, spent, trade, closed, transferred or given anything away in the last three (3) months, such as money, motor vehicle, bank accounts, money from legal/accident settlement, insurance or anything else? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                                               | <input type="checkbox"/> VERIFIED |                                                       |
|                            | If "Yes", explain below:                                                                                                                                                                                                                                                                                            |                          |                                               | <input type="checkbox"/> VERIFIED |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     |                          |                                               |                                   |                                                       |
| <b>22</b>                  | Have you, your spouse, or domestic partner received money from insurance, court settlement, inheritance, lottery or anything else in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                    |                          |                                               |                                   |                                                       |
|                            | If "Yes", complete below:                                                                                                                                                                                                                                                                                           |                          |                                               |                                   |                                                       |
|                            | Source                                                                                                                                                                                                                                                                                                              | Date received            | Amount                                        |                                   |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     |                          | \$                                            |                                   |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     |                          | <input type="checkbox"/> VERIFIED             |                                   |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     |                          | <input type="checkbox"/> BANK BALANCE \$      |                                   |                                                       |
| <b>23</b>                  | Do you, your spouse, or domestic partner have access to, or expect to receive, any of the following resources?                                                                                                                                                                                                      |                          |                                               |                                   |                                                       |
|                            | Check <b>Yes</b> or <b>No</b> for each source.                                                                                                                                                                                                                                                                      |                          |                                               |                                   |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     | Yes                      | No                                            |                                   |                                                       |
|                            | Cash                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Trust funds                                           |
|                            | Uncashed checks                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | IRA or Keogh plans, etc.                              |
|                            | Saving accounts                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Retirement funds                                      |
|                            | Checking accounts                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Employee deferred comp.                               |
|                            | Credit union accounts                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Stocks, bonds, etc.                                   |
|                            | Oil, mining or minerals                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Life insurance                                        |
|                            | Burial plots, trust, etc.                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Life estate in property                               |
|                            | Income tax refund                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   | Gate money                                            |
|                            | Other                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/>                      |                                   |                                                       |
|                            | If "Yes", complete below:                                                                                                                                                                                                                                                                                           |                          |                                               |                                   | <input type="checkbox"/> OTHER                        |
|                            | Type                                                                                                                                                                                                                                                                                                                |                          |                                               |                                   | <input type="checkbox"/> KCDHS 22                     |
|                            | Owner                                                                                                                                                                                                                                                                                                               |                          |                                               |                                   | <input type="checkbox"/> BEHICLE REGISTRATION ON FILE |
| Account #                  |                                                                                                                                                                                                                                                                                                                     |                          | CLASS CODE _____                              |                                   |                                                       |
| Source name/address        |                                                                                                                                                                                                                                                                                                                     |                          | VALUE \$ _____                                |                                   |                                                       |
| <b>24</b>                  | Do you, your spouse, or domestic partner own or have your name on the registration of any motor vehicles (even if not running)? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                            |                          |                                               |                                   |                                                       |
|                            | If "Yes", complete below:                                                                                                                                                                                                                                                                                           |                          |                                               |                                   |                                                       |
|                            | Vehicle (1)                                                                                                                                                                                                                                                                                                         |                          | Vehicle (2)                                   |                                   |                                                       |
|                            | Owner of vehicle                                                                                                                                                                                                                                                                                                    |                          |                                               |                                   |                                                       |
|                            | Year/make/model                                                                                                                                                                                                                                                                                                     |                          |                                               |                                   |                                                       |
|                            | License number                                                                                                                                                                                                                                                                                                      |                          |                                               |                                   |                                                       |
|                            | Estimated value                                                                                                                                                                                                                                                                                                     |                          |                                               |                                   |                                                       |
|                            | Balance owed                                                                                                                                                                                                                                                                                                        |                          |                                               |                                   |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     |                          | <input type="checkbox"/> VERIFICATION ON FILE |                                   |                                                       |
| <b>25</b>                  | Do you, your spouse, or domestic partner own/have any other personal property, such as antiques, jewelry, computers, tools or guns, worth at least \$100? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                  |                          |                                               |                                   |                                                       |
|                            | If "Yes", complete below:                                                                                                                                                                                                                                                                                           |                          |                                               |                                   |                                                       |
|                            | Item                                                                                                                                                                                                                                                                                                                | Value                    | Amount owed                                   | Date bought                       |                                                       |
|                            |                                                                                                                                                                                                                                                                                                                     |                          |                                               |                                   |                                                       |

|                                                                                                                                                                                                                |               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| <b>CERTIFICATION</b>                                                                                                                                                                                           |               |
| I understand the questions on this form. I understand the penalties if I give wrong facts, or fail to report all facts or situations that may affect my eligibility of benefits for General Assistance.        |               |
| I declare under penalty of perjury under the laws of the United States of America, the State of California and the County of Kern that the information this statement of facts is true, correct, and complete. |               |
| _____<br>SIGNATURE                                                                                                                                                                                             | _____<br>DATE |
| _____<br>SPOUSE/REGISTERED PARTNER SIGNATURE                                                                                                                                                                   | _____<br>DATE |
| _____<br>WITNESS                                                                                                                                                                                               | _____<br>DATE |
| _____<br>HUMAN SERVICES TECHNICIAN'S SIGNATURE                                                                                                                                                                 | _____<br>DATE |

