**LA COMMUNITY CARE CORP (LACCC) PROGRAM**

**SELF-ATTESTATION FORM**

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| **IDENTIFYING INFORMATION** | | | | | |
| APPLICANTS NAME: | | | | SSN Last 4 Digits: | |
| Is participant already in CalJOBS and enrolled in WIOA?  YES  NO | | | | If YES, CalJOBS User ID: | |
|  | | | | | |
| **COVID-19 IMPACT (EMPLOYMENT)** | | | **OTHER** | | |
| Laid off due to coronavirus COVID-19 pandemic  Experienced a reduction in hours and/or pay due to COVID-19  Unable to work due to the following COVID-19 related reasons:  Subject to quarantine.  Caregiver for someone who is subject to quarantine.  Need to care for children because of school closure or closure of other child care provider.  At higher risk of getting seriously ill from COVID-19, or lives with someone at higher risk, as outlined on the California Department of Public Health COVID-19 website.  Required to telework, but do not have the necessary equipment. | | | □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provide description:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| My work separation from employer was during the coronavirus quarantine | | | | | |
| Employer Name | Employer Address | | | | |
| Employer Contact | | | | | Employer Phone |
| Job Title | | | | | Layoff Date |
| I applied for Unemployment Insurance | | | | | |
| EDD Office Location:  Online | | | | | Date Applied |
| **APPLICANT SIGNATURE** | | | | | |
| **I hereby certify under penalty of perjury that the information above is true and correct to the best of my knowledge.** | | | | | |
| Applicant Signature | | | | | Date |
| Applicant Address (if not already a WIOA participant) | | | | | |
| **FOR OFFICE USE ONLY: STAFF CERTIFICATION** | | | | | |
| **I certify that the individual whose name appears above provided the information recorded on this form.** | | | | | |
| Agency Name: | | Staff Name: | | | |
| Applicant Signature | | | | | Date |
| Comments: | | | | | |