**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 corona virus 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 another childcare 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:  |