90-150 APPENDIX A. FORM 11-14 HHSA

SAN DIEGO COUNTY
HEALTH AND HUMAN SERVICES AGENCY
THIRD PARTY VERIFICATION

To be used to record information from third parties, which relate to a failure to complete General Relief program requirements and which may lead to a case termination, reduction in benefits, and/or a sanction.

Client Name:_____ Case Number:_____Worker Number: _____

Name and title of third party: _____

Organization of third party: _____

Phone Number: _____ Date contacted: _____

Use direct quotes as much as possible for the following items.

1. JOB TERMINATION

What was the reason for the job termination?
Fired _____ Quit _____ Layoff _____ Other _____ Please explain:_____

_____

Was client capable of doing this job? _____ Date of termination: _____

What was the monthly salary? _____

2. WORK PROJECT

What days did the client fail to attend? _____

_____

What was the reason? _____

Was the client sent home from Work Project? _____ Why?_____

Date: _____ Time: _____Location: _____

3. JOB SEARCH

Was a written application made? _____

4. OTHER THIRD PARTY CONTACTS

Name of person completing form: _____ Date: _____