

# 90-150 APPENDIX A. FORM 11-14 HHSA

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**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: \_\_\_\_\_