

# GENERAL ASSISTANCE APPLICATION PACKET

**If you are applying for GENERAL ASSISTANCE:**

**Complete and return the following:**

**DSS 5100: Application for GENERAL ASSISTANCE APPLICATION**

- Submit at ANY Regional Office reception window
- An appointment will be made for a Face-to-Face interview
- Open Monday through Friday 8:00am-5:00pm

## **Office Locations**

**Anderson: 2889 East Center Street**  
**Burney: 36911 Main Street (Hwy. 299E)**  
**Downtown Redding: 1220 Sacramento Street**  
**Enterprise: 2757 Churn Creek Road**  
**Shasta Lake: 4216 Shasta Dam Boulevard**  
**South Redding: 2460 Breslauer Way**

***For Information Call:***

**General Assistance Unit: (530) 229-8150**

The County of Shasta does not discriminate on the basis of disability in admission to, access to, or operation of its buildings, facilities, programs, services or activities. The County does not discriminate on the basis of disability in its hiring or employment practices.

GENERAL ASSISTANCE

Application

**Shasta County Health and Human Services Agency**

2460 Breslauer Way, Redding, CA 96001

36911 Main St (Hwy 299E) Burney, CA 96013

*Please complete the information below. **PLEASE PRINT IN INK.** If you have a disability or need help with this application, let the County know and someone will assist you. Application is not considered received by HHSA Regional Services unless it contains a minimum of Applicant Name, Household Mailing Address (including PO Box or General Delivery) and Signature of Applicant.*

**Section 1:** Please tell us about yourself.

**APPLICANT NAME:** \_\_\_\_\_  
LAST FIRST MI TELEPHONE NUMBER

**US CITIZEN**  YES  NO If no, describe current immigration status \_\_\_\_\_

**MARITAL STATUS:**  Single  Separated  Divorced  Married (complete spouse info)

**HOW LONG HAVE YOU LIVED IN SHASTA COUNTY?** \_\_\_\_\_

**DO YOU INTEND TO PERMANENTLY RESIDE IN SHASTA COUNTY?**  Yes  No

**IF NO, PLEASE EXPLAIN:** \_\_\_\_\_

**SPOUSE NAME:** \_\_\_\_\_  
LAST FIRST MI TELEPHONE NUMBER

**US CITIZEN**  YES  NO If no, describe current immigration status \_\_\_\_\_

**PHYSICAL ADDRESS:** \_\_\_\_\_  
HOUSE NUMBER STREET CITY STATE ZIP

**MAILING ADDRESS:**  Same as above  PO Box \_\_\_\_\_  Address Below  
BOX NUMBER CITY ZIP

\_\_\_\_\_  
HOUSE NUMBER STREET CITY STATE ZIP

**ARE YOU CURRENTLY HOMELESS?**  YES  NO

**DO YOU PAY RENT AND/OR UTILITIES?**  YES  NO

If yes, how much? \_\_\_\_\_ To whom? \_\_\_\_\_

**LANGUAGE:** The County will provide an interpreter at no cost to you.

What language do you prefer to read (if not English)? \_\_\_\_\_

What language do you prefer to speak (if not English)? \_\_\_\_\_

If you are deaf or hard of hearing, please check here



GENERAL ASSISTANCE

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**EMPLOYMENT HISTORY** (last 2 years)

**Applicant**

Employer	Location	Type of Work	From	To	Reason for Leaving

**Spouse (if applicable)**

Employer	Location	Type of Work	From	To	Reason for Leaving

**INCOME** (received in the last 30 days)

Type	Yes	No	Source	Amount	How often received?	Date received	Expected to continue?
Job (including side jobs)							
Gifts or contributions							
Unemployment (UIB)/ State Disability (SDI) benefits							
Worker's Compensation							
Child/Spousal Support							
Revenue Share (Tribal)							
Union benefits or pensions							
Social Security							
Pensions or retirement							
Military allotment or pension							
Railroad benefits							
Property income (e.g. oil, mining and mineral rights, trust deeds and notes).							

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Type	Yes	No	Source	Amount	How often received?	Date received	Expected to continue?
Trust fund							
Income from selling personal property							
Veterans benefits							
Rental Income							
Interest income							
Grants, loans, or scholarships							
Other							

**RESOURCES**

Type	Yes	No	Current value	Amount owed	Description of property	Account #	In whose name is the resource listed?
Cash on hand							
Checking							
Savings							
Stocks or Bonds							
Notes, mortgages, trust deeds							
Trust funds							
Trustee or beneficiary of an estate							
Life insurance policies							
Vehicles							
Trailers or motorhomes							
Recreational vehicles							
Tools							
Burial plots, trusts							
Other property							
Land or buildings							

Have you or your spouse received a lump sum (e.g. sale of property, settlements) in the last 12 months?  YES  NO

Source \_\_\_\_\_ Amount \_\_\_\_\_ Date received \_\_\_\_\_

Have you or your spouse sold, transferred or given away any property in the last 12 months?  YES  NO

Item description \_\_\_\_\_ Value \_\_\_\_\_

Amount received \_\_\_\_\_ Date received \_\_\_\_\_

GENERAL ASSISTANCE  
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**SECTION 4:**

	Applicant	Spouse (if none, leave blank)
Have you ever thought you need to cut down on your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have people expressed concern over your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently working with a rehabilitation program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>➤ Program Name</li> <li>➤ Counselor's Name</li> </ul>		

GENERAL ASSISTANCE  
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**Section 5:** *Please review then sign and date below.*

I agree to disclose my financial condition and will give all information necessary to establish eligibility for aid and/or services.

I understand any changes in circumstances concerning income, property, household composition, or any condition which may affect my eligibility must be reported within 5 days to my Eligibility Worker and must also be reported on the General Assistance Monthly Income Report, which is due by the 5<sup>th</sup> working day each month.

I understand that if I am required to attend Drug and Alcohol classes I will also provide the Verification of Participation in Alcohol/Drug Rehabilitation program (Form DSS 5080A) with my Income Report each month.

I understand any misrepresentations or omissions of known facts at the time of this application or thereafter may be the basis for criminal prosecution and/or discontinuance of benefits.

I understand any payments received that are not compensation for work performed must be repaid to the County and collection efforts may be through a private collection agency.

I understand and certify, under penalty of perjury, that all my answers on this Application are correct and complete to the best of my knowledge.

SIGNATURE OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF SPOUSE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF WITNESS (IF SIGNED WITH MARK) OR PERSON HELPING TO COMPLETE THIS FORM  
\_\_\_\_\_ DATE \_\_\_\_\_

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County Use Only

GAS Case Number \_\_\_\_\_ C-IV Case Number \_\_\_\_\_ Active MC/CF \_\_\_\_\_



GENERAL ASSISTANCE  
PROGRAM INFORMATION

- **General Assistance is a loan and will need to be paid back.**
- You must complete the full application process including attending a face-to-face interview and providing all required verifications.
- The interview appointment is required to determine your eligibility for the General Assistance program.
- You will receive a Verification Request form listing any documents you will need to return within 10 days of your interview.
- Verifications can be returned at any Regional Office.
- You may require a follow up appointment to sign additional eligibility documents at the Breslauer or Burney office.
- Your benefit amount will be issued to an E.B.T. card once we have determined you are eligible to the GA program and have all application documents have been signed.
  
- **You must turn in a GA INCOME REPORT EVERY MONTH you are on the program.**
  - Your **INCOME REPORT** is due by the 5th of the month.
  - Late income reports may result in the delay or discontinuance of your benefits.
  - Other documents may be requested by your GA Eligibility Worker, such as, medical reports, job contacts, SSI documents, etc. Failure to provide required documents may result in the denial or discontinuance of your benefits.
  
- Shasta County General Assistance (GA) Program is divided into two different components based on the situation and eligibility of clients. Funds received through GA are considered a loan.
  - **Employable Component**

The Employable component is for ready-to-work clients. The time limit is 3 months in a 12-month period. Participants are required to attend a Supervised Job Search where they learn job search and interviewing skills. Participants must actively look for work and turn in weekly job search forms. During the final month, participants may be required to participate in Work Experience. This allows the client to gain skills while paying off a portion of their loan.
  - **Incapacitated Component**

The Incapacitated component is for clients who have work limitations. It can also assist those who are waiting for Social Security applications to be granted. Participants must provide periodic proof of their disability in order to remain eligible and keep their SSI application up-to-date.

# SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY

## CALFRESH EMPLOYMENT AND TRAINING PROGRAM CFET

**Employable clients who are currently active on the CalFresh Program and have been granted General Assistance are required to participate in the CalFresh Employment and Training Program (CFET)**

The CalFresh Employment and Training program is composed of certain components:

❖ Component #1: ORIENTATION

Orientation is held every Tuesday and Wednesday. A CalFresh Employment and Training Worker (CFET ETW) conducts a one-on-one assessment to determine barriers and define a plan to achieve goals. This is a mandatory appointment to remain eligible to the program.

❖ Component #2a: SPECIALIZED JOB CLUB WORKSHOP

All participants are required to attend the Specialized Job Club Workshop. The workshop is a four-day training course in resume preparation, job application completion, job interviewing techniques, how to write letters to potential employers, dress, attitude, and self-esteem.

❖ Component# 2b: SUPERVISED WORK SEARCH

The CFET ETW will provide each participant with a statement that describes the Job Search requirements. You will be required to spend at least 12 hours in the first 30-day period searching for employment. You must enter a minimum of 10 potential job contacts on the Job Search Log form weekly. At least 5 of these contacts must include the submission of a job application. General Assistance staff will review the Job Search Log forms and will conduct random telephone verification with the employer contacts.

❖ Component#3: WORK EXPERIENCE

If you have not obtained employment in the first 2 months of Supervised Job Search, you may be assigned a Work Experience position at Shasta County Health and Human Services. Your required total monthly work hours will be determined by the County. You will be notified of your work requirements at that time.

## **GENERAL ASSISTANCE EXTRAS:**

Eligible adults are supported on their efforts toward self-sufficiency through referrals and information to:

- CalFresh Employment and Training Program
  - Vocation Testing
  - Work Experience
  - Drug and Alcohol Programs
  - Job Centers
  - Shasta 211
  - Mental Health
  - Community Health Advocates
- And more...

## **WHERE TO APPLY:**

**Shasta County Health and Human Services  
Any Regional Office:**

**South Redding:  
2460 Breslauer Way**

**Downtown Redding:  
1220 Sacramento St.**

**Enterprise:  
2757 Churn Creek Rd.**

**Anderson:  
2889 East Center St.**

**Shasta Lake City:  
4216 Shasta Dam Blvd.**

**Burney:  
36911 Main St. (Hwy 299E)**

**For More Information regarding the  
General Assistance Program,  
Please call:  
530-229-8150**

DSS 5102 10/2019

# **GENERAL ASSISTANCE PROGRAM**

**What is the General Assistance?  
Who is it for?  
How to apply ?**

## ABOUT GENERAL ASSISTANCE....

### WHAT IS GENERAL ASSISTANCE?

General Assistance (GA) is a county funded eligibility based loan program which provides cash benefits to those who are not supported by their own means, friends, relative, by other public funds, and by other assistance programs.

### WHO CAN APPLY?

Any resident of Shasta County who has been here for 15 days and intends to stay in the county.

### HOW DO I APPLY?

Visit any Shasta County HHS Regional Office and fill out a General Assistance Application packet. Take it to the reception window and they will schedule an interview appointment for you to meet with a General Assistance Eligibility Worker (GA EW).

### WHAT NEXT?

You will attend the appointment and meet with the GA EW. All of your eligibility will be reviewed and any questions you have can be answered. The GA EW will give you a list of necessary verifications you will need to provide. Once you have your documents you can take them to any Regional Office to turn them in. A GA EW will contact you to go over your information.

### WHAT WILL I NEED TO PROVIDE?

You may need, but not limited to the following; DL/ID, social security number, alien status (if you are not a current citizen), house-hold/living arrangement, income, bank statements, vehicle registrations, property and medical verification of disability.

### HOW MUCH PROPERTY CAN I HAVE?

You can have but not limited to the following; The home you live in, one licensed and registered automobile or motorcycle, additional vehicles/boats/RV/computers not having combined worth of over \$300.00, work supplies, tools, equipment, clothing, personal jewelry, bank account or cash under \$100.00 and funeral/burial trusts not exceeding \$1000.00.

### WHAT IS THE MAXIMUM BENEFIT?

If you are single and 100% eligible the maximum benefit is up to \$520.00. Allowable income will reduce the amount of GA awarded

### AM I ELIGIBLE FOR GA IF I RECEIVE CALFRESH?

Receiving CalFresh neither entitles you to GA nor excludes you from receiving them.

### HOW DO I ACCESS MY GA BENEFITS?

You will receive your cash benefits on an EBT (electronic benefits transfer) card. You may use this card at any participating retail store, bank or ATM.

### WHAT IF I AM DISABLED?

GA has the Incapacitated Component for those who are disabled and are applying for SSI or waiting for an SSI determination. GA has two disability advocates you can make an appointment with to discuss the SSI process.

### WHAT IF I WANT TO FIND A JOB?

GA has a 3 month Employable Component. Through the CalFresh Employment Training Program (CFET) you will receive a one-on-one assessment to determine any barriers and skills and/or training needed. You will attend workshops to learn interviewing skills, how to create resumes and how to apply for jobs to get the career you want.

### WHO DO I CALL IF I HAVE QUESTIONS?

You can call the General Assistance Unit directly at 229-8150.



Shasta County  
**Health & Human  
Services Agency**

*Working together to provide options and opportunities to individuals and families in need.*

[www.co.shasta.ca.us](http://www.co.shasta.ca.us)

# GENERAL ASSISTANCE UNIT: INCOME REPORT

## MONTHLY INCOME REPORT FOR MONTH OF:

**DUE BY THE 5TH OF EVERY MONTH**

**FILL OUT FORM COMPLETELY \* SIGN \* RETURN TO THE HEALTH AND HUMAN SERVICES AGENCY WITH ALL VERIFICATION REQUESTED OR YOUR GENERAL ASSISTANCE WILL BE DISCONTINUED.**

Client Name / Address:

SHASTA COUNTY  
HEALTH AND HUMAN SERVICES AGENCY  
P.O. Box 496005  
Redding, CA 96049-6005

**Worker:**  
**Case Number:**

### HOUSEHOLD CHANGES

**1. HAVE YOU HAD ANY CHANGES IN YOUR HOME IN THE LAST MONTH?**     YES     NO

**IF "YES" PLEASE EXPLAIN BELOW, INCLUDE:**

- ANYONE WHO MOVED IN OR OUT OF YOUR HOME
- MARRIED
- RECOVERED FROM OR BECAME DISABLED
- ENTERED/LEFT A HOSPITAL OR OTHER PUBLIC OR PRIVATE INSTITUTION (JAIL)
- STARTED/REFUSED/LOST/QUIT/JOB TRAINING
- BECAME PREGNANT

Person	Relationship to You	Age	What Changed?	Date

### INCOME

**2. HAVE YOU RECEIVED ANY INCOME LAST MONTH?**     YES     NO

**IF "YES" PLEASE EXPLAIN BELOW, INCLUDE:**

- GA
- UNEMPLOYMENT
- DISABILITY/WORKMAN'S COMP.
- MILITARY BENEFITS
- TAX REFUNDS
- LOANS/GRANTS
- ANY OTHER MONEY YOU RECEIVE
- SETTLEMENTS

**\*\*YOU MUST SEND PROOF OF ALL INCOME, EARNED AND UNEARNED\*\***

Who received income, money, or benefits?	Relationship to You	Age	Source of income, money, benefits (if earnings, list employer)	Date
	SELF			

**MISCELLANEOUS**

3. LIST ALL PERSONS LIVING IN YOUR HOME AND PROVIDE THE REQUESTED INFORMATION (including yourself):

Name	Age	Relationship to You
		SELF

4. PLEASE ANSWER THE FOLLOWING:

1. DO YOU PAY RENT/MORTGAGE/TRAILER PYMNT?  YES  NO  
IF YES, HOW MUCH: \$ \_\_\_\_\_ ARE UTILITIES INCLUDED?  YES  NO

2. ARE YOU HOMELESS?  YES  NO IF YES, WHERE DO YOU SLEEP? \_\_\_\_\_  
HOW LONG HAVE YOU BEEN THERE? \_\_\_\_\_  
IF YOU ARE NOT STAYING AT A PHYSICAL ADDRESS, GIVE DIRECTIONS TO WHERE YOU ARE STAYING:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. I HAVE OTHER INFORMATION TO REPORT:  YES  NO IF YES, EXPLAIN BELOW:  
INCLUDE NEW ADDRESS AND/OR PHONE SHOW ANY EXPECTED CHANGES NEXT MONTH IN YOUR HOUSEHOLD, EMPLOYMENT, INCOME OR PROPERTY.  
\_\_\_\_\_  
NEW Address (if different than the one on the front)  
\_\_\_\_\_  
Next Month's Changes  
\_\_\_\_\_

After answering all questions, you must sign the form. If you make a mark, a witness must also sign below. An interpreter or someone completing this form for you must also sign. Withholding of information or misrepresentation of fact can result in legal prosecution when signed under penalty of perjury.

I UNDERSTAND THAT I MUST CONTACT MY ELIGIBILITY WORKER IMMEDIATELY AND REPORT ANY UNEXPECTED CHANGE THAT OCCURS OR IF I HAVE ANY DOUBT ABOUT NEEDING TO REPORT ANY CHANGE.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number



Shasta County  
**Health & Human  
Services Agency**

**Regional Services  
Branch**

In order to receive General Assistance, you are required to participate in the Employment and Training program. Any medical condition that would prevent you from taking part in employment or training activities must be verified.

Because you have reported circumstances which may prevent you from participating in the General Assistance Employment and Training program, I am providing you with forms to have your health care provider or other qualified professional complete. Be sure to complete the release section of the form authorizing your provider to release medical information to the General Assistance program. **You may need to make an appointment with your provider to have this packet completed.**

Sincerely,

*General Assistance Eligibility Worker*

**DEAR HEALTH CARE PROVIDER:**

The Shasta County General Assistance program requires individuals to participate in training and/or work activities as a condition of receiving temporary cash assistance.

- We ask your help in evaluating this individual by providing us with information regarding how his/her mental and/or physical condition will affect his/her ability to participate in training and/or work activities.
- With this information, we can better assign the individual to an appropriate activity (*with the appropriate accommodations*). It will also help us to determine if the individual's condition will enable him/her to participate or successfully complete training and/or work activities.

Please complete **Section 3** of the attached form and sign (or have your authorized representative sign) the Certification in **Section 4**.

Your assistance is appreciated and necessary to determine any medical limitations.

Thank you,

_____	(530) _____	(530) 225-5288
Eligibility Worker Name	Phone Number	Fax Number



**SECTION 3: LICENSED HEALTH CARE PROVIDER STATEMENT**

1. Does this patient have a physical and/or mental condition that prevents or substantially reduces his/her ability to participate in training and/or work activities?

- Yes (If yes, please ***complete the rest of the form*** below)
- No (If no, please complete ***Section 4*** only)

2. Patient is currently in treatment:  Yes  No

3. Next Appointment Date: \_\_\_\_\_

4. The condition is:  Chronic  Acute

5. Date condition became disabling (month/year): \_\_\_\_\_ Expected to last until (month/year): \_\_\_\_\_

6. When did you begin treating the patient/client for this condition (month/year): \_\_\_\_\_

7. Is this patient able to work or participate in training activities:  Yes  No

If **yes**, they can participate \_\_\_\_\_ **hours per day** and \_\_\_\_\_ **days per week**.

8. Physical Capacities (e.g., N/A, lifting, standing, reaching, etc.): \_\_\_\_\_

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9. Mental Capacities (e.g., social functioning, task completion, adaptation to work or work-like situations, etc.):

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**SECTION 4: HEALTH CARE PROVIDER CERTIFICATION**

Signature of Provider or Provider's Authorized Representative		Date
Print Name and Title/Specialty		Phone Number
Street Address (Mailing address, if different)	City	State/Zip Code

**Thank you for your help!**

## SHASTA COUNTY

2460 Breslauer Way Redding, CA 96001

### Health and Human Services Agency

(530) 229-8150 / Fax (530) 245-6317

Melissa Janulewicz, RN, PHN, Branch  
 Director Regional Services

### VERIFICATION OF PARTICIPATION IN ALCOHOL/DRUG REHABILITATION PROGRAM

Client Name:	Month of Referral:	Case Number:
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To the Client:

You are required to participate in, and provide proof of your participation in a recognized mental health and/or drug/alcohol rehabilitation program in order to continue to receive General Assistance benefits.

You must follow the terms of your treatment agreement. If you have been diagnosed as having drug or alcohol abuse problems, you must attend AA/NA meetings or any other meetings conducted through an acceptable drug/alcohol rehabilitation program. Have the person that conducted each meeting indicate the date and location of the meeting with his or her signature, initials or stamp verifying your attendance.

Return the completed form with your monthly income report at the beginning of the month. When your completed form is received, your eligibility worker will send you a new form to have completed.

**FAILURE TO COMPLETE THIS FORM WILL RESULT IN DENIAL OR DISCONTINUANCE OF YOUR GENERAL ASSISTANCE**

\*\*TO BE COMPLETED BY COUNSELOR\*\*

MEETING DATE	LOCATION	COUNSELOR/FACILITATOR SIGNATURE OR INITIALS

I declare, under penalty of perjury, that this report is true and correct to the best of my ability. I understand that the General Assistance unit may verify the information on this report by contacting the Counselor/Facilitator listed.

I understand that my failure to complete this form completely and correctly can result in a decrease and/or discontinuance of benefits.

I understand that failure to return the verification form by the 5<sup>th</sup> of the month with the monthly income report will result in the discontinuance of my loan and I will need to reapply if I still need help.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Recipient