



# UNIVERSAL ADULT APPLICATION

**PLEASE PRINT**

1. Name: Last Name First Name M.I.			2. Social Security Number:	
3. Address: _____ Street Number and Name (no P.O.Box address) _____ City State ZIP Code			4. Date of Birth:	6. Do you have any disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
			5. Phone No.:	
7. Is this a Public Housing Address? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			8. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
9. Is this Section 8 Housing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			10. Selective Service Registration No.:	
11. Are you a U.S. Citizen? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>No</b> , bring I-551 form or other documentation verifying work authorization.			12. Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , can you provide a copy of your DD-214 or any VA document?	
13. Did you arrive in this country in the last five years as a refugee?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			14. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
15. Are you attending school? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If <b>Yes</b> , Name of School:			16. Current Grade Level or Highest Grade Completed: _____	
17. Indicate your skills, (e.g., computer [PC or Macintosh]; software programs; language(s) spoken other than English; typing [wpm]; others).				
18. Number of family members living in your household (including yourself): ____  The term "family" means two or more persons related by blood, marriage, or decree of court who are living in a single residence and are included in one or more of the following categories: husband, wife, and dependent children, parent or guardian and dependent children, husband and wife				
List all family members living with you in the same household and their income for the last six months, if any.				
HOUSEHOLD MEMBER(S)	AGE	RELATIONSHIP (FATHER, MOTHER, ETC.)	AMOUNT OF INCLUDABLE INCOME	SOURCE(S) OF INCOME
You, the Applicant		Self	Last 6 months	
			Last 6 months	
			Last 6 months	
			Last 6 months	
			Last 6 months	
			Last 6 months	
			Last 6 months	
If needed, attach a separate page to list other family members in the household				<b>BRING EVIDENCE OF INCOME</b>
Income <b>does</b> include: Gross wages and salary, government retirement payments, pensions, social security payments, net rents, alimony, WIA OJT wages.				
Income <b>does not</b> include: Public assistance, food stamps, child support, inheritance, one-time awards, Unemployment Insurance (UI) benefits.				

Do you or any family member(s) presently residing with you receive public assistance? ..... Yes  No  
 If Yes, check all that apply:  CalWORK's (California Work Opportunities and Responsibility for Kids)

- PAES (Personal Assisted Employment Services)  Food Stamps   
 RCA (Refugee Cash Assistance)  Other (specify) \_\_\_\_\_

Who receives these benefits?  
 Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Case Number \_\_\_\_\_ Amount per Month \_\_\_\_\_ Start Date \_\_\_\_\_

Are you currently receiving unemployment insurance? ..... Yes  No

Ethnicity (Please check one or more)

- African American  Caucasian  Hawaiian  Laotian  Other Asian  
 Amer.Ind./Alask.Nat.  Chinese  Hispanic (Latino)  Pacific Islander  
 Asian Indian  Filipino  Japanese  Samoan  
 Cambodian  Guamanian  Korean  Vietnamese

**Work Experience List the four most recent jobs in the last four years (use additional paper if needed):**

Employer Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Job Title: \_\_\_\_\_  
 Job Duties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
 Hourly Wage: \_\_\_\_\_ Hours per Week: \_\_\_\_\_  
 Reasons for Leaving: \_\_\_\_\_

Employer Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Job Title: \_\_\_\_\_  
 Job Duties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
 Hourly Wage: \_\_\_\_\_ Hours per Week: \_\_\_\_\_  
 Reasons for Leaving: \_\_\_\_\_

Employer Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Job Title: \_\_\_\_\_  
 Job Duties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
 Hourly Wage: \_\_\_\_\_ Hours per Week: \_\_\_\_\_  
 Reasons for Leaving: \_\_\_\_\_

Employer Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Job Title: \_\_\_\_\_  
 Job Duties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
 Hourly Wage: \_\_\_\_\_ Hours per Week: \_\_\_\_\_  
 Reasons for Leaving: \_\_\_\_\_

In case of an on the job injury, will you allow us to provide for emergency medical treatment?......Yes  No  
In no, please explain:

In case of an emergency please provide the name and telephone number of a relative or friend **not** living with you.  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

I hereby authorize and give my consent:

To have my picture taken for program publicity or for program identification. .... Yes  No

To be filmed or videotaped for program publicity purposes only. .... Yes  No

I declare that no member of my family is engaged in an “administrative capacity” for the Office of Economic and Workforce Development (OEWD), Workforce Investment of San Francisco (WISF) Board, or any of the other participating agency, as well as other officials who may have influence or control over the administration of the program (such as executive director, director, president, vice-president and unit chiefs, persons who have selection, hiring, placement or supervisory responsibilities for participating agency systems) excluding economically disadvantaged members of the OEWD, WISF, or other participating agency. .... Yes  No

I understand that if any of the information I have supplied is found to be inaccurate (and I understand and consent that some or all of it may be verified) I may be faced with these consequences: .... Yes  No

A. Immediate termination from my internship, work, or training;  
B. possible civil or criminal prosecution;  
C. requirement to pay back all funds I have received and to reimburse all costs incurred on my behalf.

I declare under penalty of perjury that the foregoing statements on this application are true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant Date

Executed in the City and County of San Francisco, State of California

If completed by someone other than the applicant:

I have reviewed all of the questions with the applicant and declare s/he understands all of the foregoing statements. I further certify this application accurately reflects her/his responses to the statements.

\_\_\_\_\_  
Signature of Preparer Date