|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SOCIAL SECURITY | CLAIMANT’S NAME | WBA | PROGRAM | WEEK 1 ENDING |
| xxx-xx- |  |  |  | 01/02/2021 |

UNANSWERED QUESTIONS, OMITTED SIGNATURE, OR DAMAGED CARD WILL DELAY YOUR BENEFIT PAYMENT. ANSWER THE FOLLOWING BY PLACING AN “X” IN A BLOCK INDICATING EITHER YES OR NO FOR THE CORRESPONDING WEEK.

**YES NO**

1. WERE YOU PHYSICALLY AND/OR MENTALLY ABLE TO WORK DURING THE WEEK CLAIMED?
2. OTHER THAN A HEALTH ISSUE, WERE YOU AVAILABLE FOR WORK DURING THE WEEK CLAIMED?
3. ARE YOU FURLOUGHED DUE TO FEDERAL SHUTDOWN?
4. DID YOU LOOK FOR WORK DURING THE WEEK CLAIMED?

**EARNINGS**

1. DID YOU PERFORM WORK DURING THE WEEK CLAIMED? IF YES, INDICATE GROSS AMOUNT BEFORE ANY DEDUCTIONS IN THE BLOCK AND COMPLETE THE SECTION BELOW.
2. DID YOU BEGIN RECEIVING A SEVERANCE OR DID THE AMOUNT PREVIOUSLY REPORTED CHANGE? IF YES, INDICATE GROSS AMOUNT IN THE BLOCK.
3. DID YOU BEGIN RECEIVING A PENSION OR DID THE AMOUNT PREVIOUSLY REPORTED CHANGE? IF YES, INDICATE GROSS AMOUNT IN THE BLOCK.
4. DID YOU BEGIN SCHOOL/TRAINING OR HAS THERE BEEN A CHANGE IN YOUR CLASS SCHEDULE THIS WEEK?
5. DID YOU REFUSE WORK, QUIT A JOB, OR YOU WERE DISCHARGED FROM A JOB DURING WEEK 1, OR WEEK 2?
6. DID YOU RETURN TO FULL-TIME WORK? IF YES, COMPLETE THE SECTION BELOW.

**CERTIFICATION:** I HEREBY CERTIFY THAT THESE STATEMENTS ARE TRUE AND CORRECT. I UNDERSTAND THAT THE LAW PROVIDES PENALTIES FOR FALSE STATEMENTS TO OBTAIN OR INCREASE BENEFITS.

**SIGNATURE**:

DATE:

# IF YOU ANSWERED YES TO QUESTIONS 5 OR 10, YOU MUST LIST THE DATE(S) OF YOUR EMPLOYMENT AND THE NAME AND ADDRESS OF YOUR EMPLOYER.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **WEEK 1: DATE(S) OF EMPLOYMENT:** | | | **Name and Address of Employer:** | |
|  | | | | |
| **List your work search activity in the space below. Please note that your work searches are subject to verification. Work searches that cannot be verified may cause you to be overpaid.** | | | | |
| **Work Search Activity - Date**  **of Contact (MM/DD/YYYY)** | | **Employer Name, Address and Phone Number** | | **Method of Contact (In-Person, Mail, Email, Online)** |
| **Week 1** |  |  | |  |
|  |  | |  |

**MAIL TO: DEPARTMENT OF EMPLYMENT SERVICES, P. O. BOX 37006, WASHINGTON, D.C. 20013. IF CHANGE OF ADDRESS. DO NOT MAIL. BRING THIS FORM TO YOUR LOCAL OFFICE**.