

Unemployment Insurance Program
P. O. Box 29225, Phoenix, Arizona 85038

FAX _____

ESTE DOCUMENTO AFECTA SU ELEGIBILIDAD PARA RECIBIR SEGURO POR DESEMPLEO. SI USTED NO LEE INGLÉS, COMUNÍQUESE CON UNO DE LOS CENTROS DE ATENCIÓN AL CLIENTE INDICADOS A CONTINUACIÓN.

Date Mailed _____

Claim Number _____

You have been scheduled for an eligibility review by Unemployment Insurance Program staff. Your eligibility for Unemployment Insurance Benefits will be reviewed based on the information you provide, and our staff will determine what services the department can provide to assist you in your reemployment efforts. If you have any questions, call **602-364-2722** if you live in the Phoenix area, **520-791-2722** if you live in the Tucson area. Outside Phoenix and Tucson call toll free **1-877-600-2722** or **1-877-877-6226** for TDD for hearing impaired (*para los sordos*).

**FAILURE TO RETURN, SIGN AND COMPLETE THIS FORM
COULD RESULT IN DENIAL OF BENEFITS**

Please enter your social security number in the space provided on the reverse of this form to avoid any potential delay in the payment of benefits. This form must be received or postmarked no later than seven days after the mailing date shown above. Mail or fax to the address or fax number shown above

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. To request this document in alternative format or for further information about this policy, Contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local

ELIGIBILITY REVIEW QUESTIONNAIRE

Claimant's Name (*Last, First, M.I.*) _____ SOC.SEC.NO _____

1. Indicate the kind(s) of work you are trying to find and length of experience in each

_____	YRS. _____	MOS. _____
_____	YRS. _____	MOS. _____
_____	YRS. _____	MOS. _____

2. Indicate the kind of work you did for your last full-time employer _____

Rate of Pay \$ _____ HR. WK. MO. Length of Employment _____

3. Lowest rate of pay you are now willing to accept for a new job _____ PER HR. WK. MO.

4. Indicate the shift(s) you are willing and able to work Day Shift Afternoon Shift Night Shift

5. Indicate the days you are willing and able to work SUN. MON. TUE. WED. THU. FRI. SAT.

6. Indicate the number of miles you are willing and able to travel to work _____

7. Indicate the means of transportation you now use Own Car Bus Bicycle Walk

Other (*Specify*) _____

	YES	NO
8. Do you have children or anyone else requiring care which would prevent you from accepting full-time employment? If yes: Please Explain _____		
9. Do you have a definite date to return to work with an employer? If Yes: Date _____ Employer's Name and Address (<i>No., Street, City, State, Zip</i>) _____		
10. Do you obtain work only through a hiring union? If Yes: Are you on the out-of work list? If yes: Most Recent Date Signed Onto the List _____ Union Name _____ Local Number _____		
11. Do you need a special license to do your work, e.g., chauffeur, barber, nurse, real estate? If Yes: Date Your License Expires _____ Type of License _____		
12. Are you or have you been in business of any kind, a corporate officer, working on a commission basis, doing any odd jobs, working part-time or full time? If yes: Please Explain _____		
13. Are you attending or planning to attend school, or have you attended school in the past six months? If yes: Name of School _____ Days/Hours of Attendance _____		
14. Are you receiving or have you applied for retirement or any other type of pension /annuity (<i>other than Social Security</i>)? If Yes: Name/Type _____ Amount _____		
15. Do you have a physical condition or disability which would limit your ability to work full time now? If yes: Please Explain _____		
16. Is there any reason you could not accept full-time work now? If yes: Please Explain _____		

CERTIFICATION: I have answered these questions for the purpose of obtaining Unemployment Insurance benefits, knowing that the law provides penalties for making false statements. I understand that I am to review this form for each week I claim benefits and if the information which I have provided, changes, I must report these changes to my local Unemployment Insurance office immediately.

Claimant Signature _____ Date _____

Deputy's Signature _____ Date _____