

ELIGIBILITY INVESTIGATION RECORD

C1 C2 C4 Process Date _____ Social Security Number _____
 Claimant Name Check _____ Issue Code _____
 Issue ID (C2) _____ Deputy ID _____ PGM _____
 Issue Status _____ Resolution _____
 Count _____ Untimely _____ 1st Affected BWE _____ REDET Reason _____
 Disqualification Start _____ Disqualification End _____ Statement 1 _____
 Statement 1 _____ ER Charge Statement _____ C5 _____
 ER Number _____ ER Name and Address _____
 City _____ State _____ ZIP Code _____
 Free Form Text C9 Release Date _____ Ltr # _____
A9 Charge? _____ NC RSN _____ Start Date if Not BYB _____ Send 100D _____

I certify I obtained the following information from the parties named.

Deputy's Name _____

FINDINGS OF FACT

Basis for Adjudication _____

Date Issue Detected _____ UB-436 Mailed (*Date*) _____ Received Yes No
 ER Protest Not Applicable Received Untimely/Adequate Information Received Timely/Adequate Information
 Not Received Received Untimely/Inadequate Information
 Received Timely/Inadequate Information

TC VM MESS (Date/Time) _____ Name _____
to RTC by (Date/Time) _____

If failure to RTC determination will be issued with the available information. Statement Date _____

Fact Finding

Equal Opportunity Employer / Program • 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.