STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

9S- East County JCC
P.O. BOX 3699
Ventura, CA 93006-9914

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COUNTY OF VENTURA

Date:
Case Name:
Case Number:
Worker Name:
Worker ID:
Worker Phone Number:

SWORN STATEMENT

Name (Last, First, Middle)			
Street Address:	City:	State:	Zip Code:
Home Telephone Number:	Contact/Cell Phone Number:		

I declare as follows:

REQUIRED

I declare under penalty of perjury that the statements made herein are true and correct to the best of my knowledge and belief. I am aware that it is unlawful to give false information.

Signature or Mark:	Date Signed:
Signature or Mark:	Date Signed: