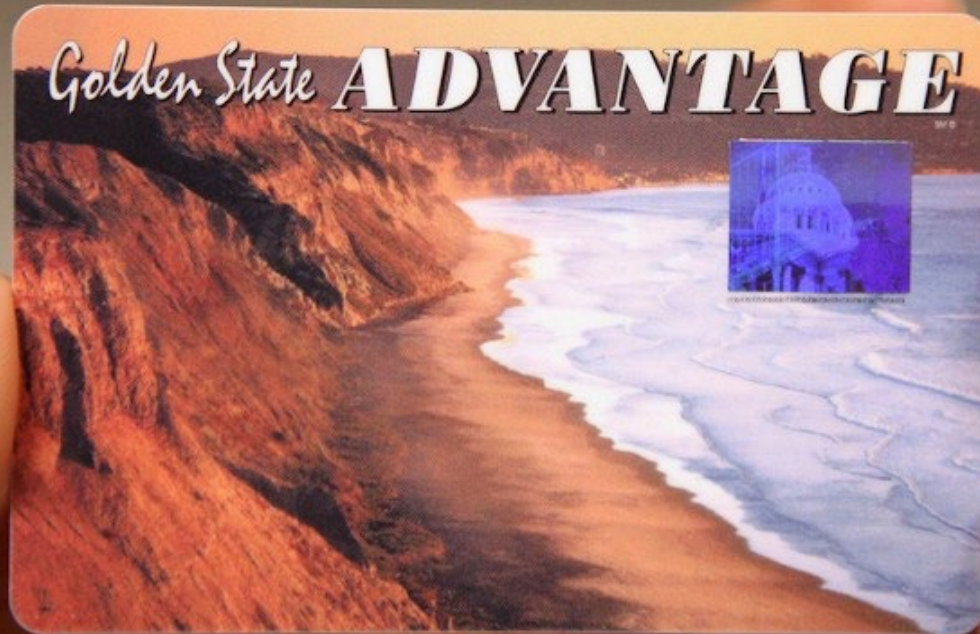


General Assistance (GA)



2000 San Pablo Ave. Oakland



Martinez Luther King Blvd

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6955 Foothill Boulevard, Oakland




8477 Enterprise Way Oakland



24100 Amador Street Hayward

24272 Amador St

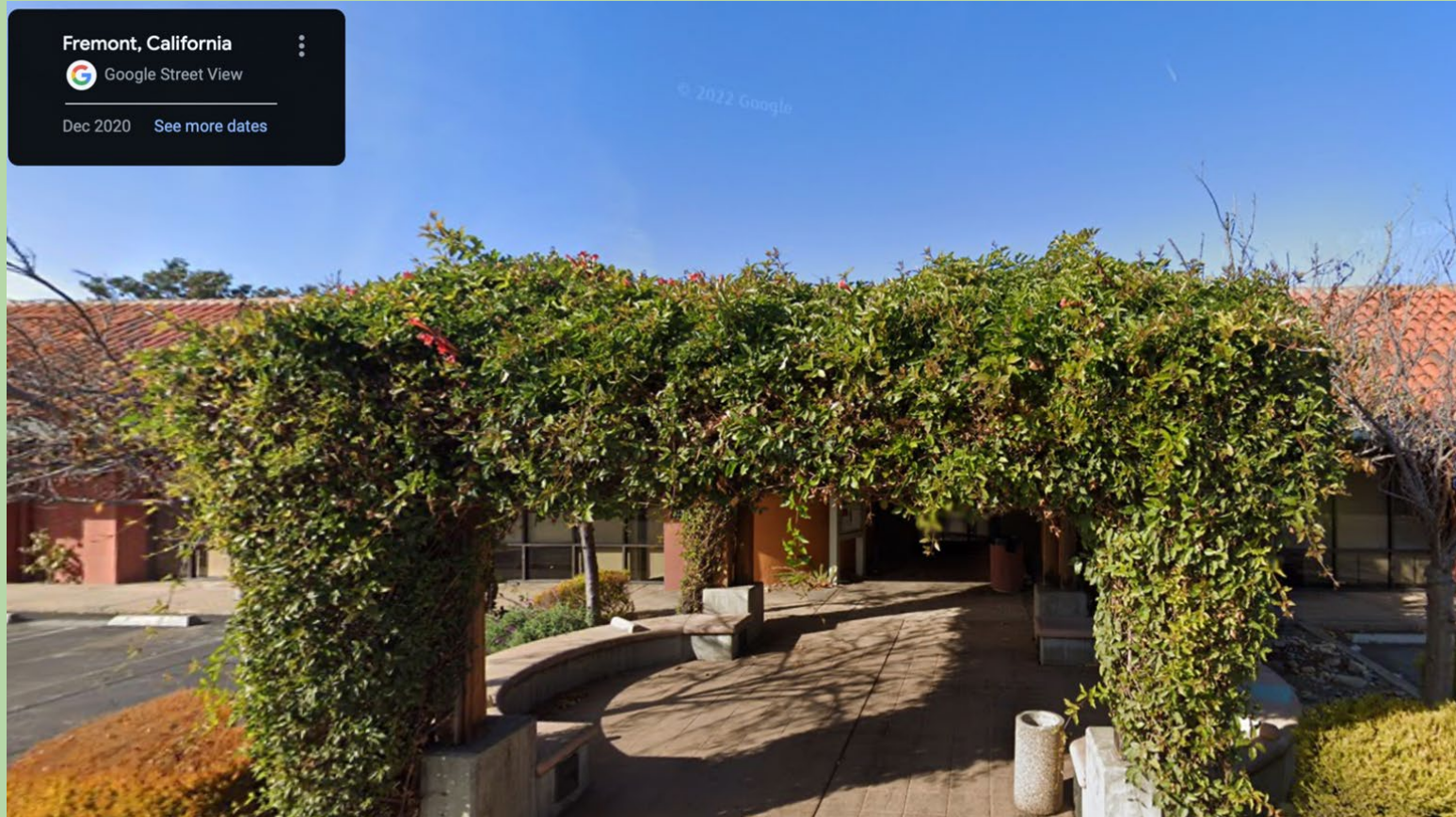
Hayward, California

 Google Street View

Jan 2023 [See more dates](#)



39155 Liberty Street, Fremont



2499 Constitution Dr. Livermore



What is General Assistance (GA)?

- General Assistance (GA) provides cash aid to indigent adults and emancipated minors who are legal residents of Alameda County and who have no other means of support.
- It is a state-mandated program that is locally administered and funded by the County of Alameda.
- The maximum cash grant for a single person on GA is \$336 per month and \$548 per month for a couple.
- GA benefits are considered a loan to the individual(s) receiving aid. *

General Assistance Eligibility

To be eligible for General Assistance individuals must be:

- A U.S. citizen or non-citizen legally in the country with no limitation on your stay;
- A resident of Alameda County for at least 15 days; and
- An adult without dependent children (Calworks)
- Applicants cannot earn income from other sources*
- Applicants may have up to \$1,000 in personal property. If they own 1 car or a home they live in, it will not be counted towards the personal property limit.
- GA is a benefit of last resort. An individual cannot be eligible for any other cash payments to be approved.

General Assistance Process

- Clients should complete paper applications with completed health questionnaire and bring it to the your local County office.
- Clients will need to complete an interview with Social Services eligibility worker in person or over the phone.
- Clients may need to complete orientation interview for new applications.
- Clients will need to complete interview with health worker for work exemption
- Clients will receive monthly benefit of \$336 distributed on their EBT card
- General Assistance (GA) regulations require that applications be processed within 30 days from application.
- Without the work exemption, GA only lasts 3 months.

GA Medical Exemption to Work Requirement



**MENTAL HEALTH CLINICIAN'S
CONFIDENTIAL REPORT**

Case Name: _____
Case Number: _____
Social Security Number: _____

PLEASE RETURN COMPLETED FORM TO:
EMPLOYMENT SERVICES DIVISION
ATTENTION: PMED
SOUTH COUNTY SELF-SUFFICIENCY CENTER
24100 AMADOR ST., HAYWARD, CA 94544
FAX NUMBER: (510) 259-2210
RETURN BY: _____

Clinician:
Please complete this report evaluating the individual listed below for mental health conditions that may prevent them from being able to work. Unless medically exempt, a General Assistance client may be required to participate in employment programs. Authorization for the release of information is on the reverse side.

Patients Name: _____
Birth Date: _____
Address: _____

Reason for Referral (to be completed by SSA Social Worker): _____

Date of Examination: _____

- | | Unable To Determine | Not Significantly Limited | Moderately Limited | Markedly Limited ^(see below) |
|---|----------------------------|----------------------------|----------------------------|---|
| A. UNDERSTANDING AND MEMORY | | | | |
| 1. The ability to remember work-like procedures. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 2. The ability to understand and remember very short and simple instructions. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| B. SUSTAINED CONCENTRATION AND PERSISTENCE | | | | |
| 3. The ability to carry out very short and simple instructions. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 4. The ability to maintain attention for extended periods-two hour segments or more. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 5. The ability to maintain regular attendance, and be punctual within customary tolerances. (These tolerances are usually strict) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 6. The ability to sustain ordinary routine without special supervision. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 7. The ability to work in coordination with or proximity to others without being unduly distracted by them. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 8. The ability to make simple work-related decisions. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 9. The ability to complete a normal workday and week-work without interruptions from psychologically based symptoms and to perform consistent pace without an unreasonable number and length of rest periods. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| C. SOCIAL INTERACTION | | | | |
| 10. The ability to ask simple questions or request assistance. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 11. The ability to accept instructions and respond appropriately to criticism from supervisors. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 12. The ability to get along with co-workers and peers without unduly distracting them or exhibiting behavioral extremes. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| D. ADAPTATION | | | | |
| 13. The ability to respond appropriately to changes in a routine work setting. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 14. The ability to be aware of normal hazards and take appropriate precautions. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

* A marked limitation is more than moderate, but less than extreme. An individual need not be totally precluded from performing an activity to have a marked limitation as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

Please describe the mental health diagnosis that is the source of any limitations noted on reverse:

Does this individual's mental health condition prevent them from working?
 NO YES If yes, in this situation:
 Temporary (if temporary, condition will improve in) _____ (months)
 Persistent (not able to work for 12 mos. or more)
If condition is persistent has it existed for 12 months or more?: yes no insufficient information to make determination
 Other: (Explain) _____

Does the patient have work restrictions related to their mental health condition(s)?
 NO YES If yes, please describe any other significant limitations such as work environment, number of hours worked, interactions with supervisors and/or customers, ability to utilize public transportation to get to and from employment.

I recommend that patient be referred for an evaluation of physical health conditions that may prevent them from being able to work.
 NO YES If yes, please state reason.

Alcohol and Other Drugs
Alcoholism: Yes No Probable (Explain) _____
Recovering Alcoholist: Yes No Probable (Explain) _____
Drug Abuse: Yes No Probable (Explain) _____
Recovering Drug Abuser: Yes No

Clinician's Name (Please Print) _____ Specialty _____
Clinician's Signature _____
Address _____
Date _____ Telephone Number _____ Fax Number _____

If the person completing this form is not a medical doctor, please sign below:
Name (Please Print) _____ Title (Please Print) _____
Signature _____

I authorize release of requested information from my record for the use of the Alameda County Social Services Agency. I know this authorization may be used by the Alameda County Social Services Agency for up to one year from this date to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the agency. This information is needed to determine eligibility for cash aid or food stamps. It is also needed to decide the type of work or training activities that I can participate in. I have read this form (or had this form read to me) before I signed my name. I know I can get a copy of this form if I ask for it.

Patient's Signature _____ Date _____



**MEDICAL STATEMENT
DOCTOR'S CONFIDENTIAL REPORT**

CASE NAME: _____
CASE NUMBER: _____
SOCIAL SECURITY NUMBER: _____

PLEASE RETURN COMPLETED FORM TO:

ATTENTION: PMED
SOUTH COUNTY SELF-SUFFICIENCY CENTER
24100 AMADOR ST., HAYWARD, CA 94544
FAX NUMBER: (510) 259-2210

RETURN BY: _____

Medical Provider:

Please complete this report evaluating the individual listed below for health conditions that may prevent them from being able to work. Unless medically exempt, a General Assistance client may be required to participate in employment programs. Authorization for the release of information is on the reverse side.

Patients Name: _____

Birth Date: _____

Address: _____

Reason for Referral for Medical Statement (to be completed by SSA Social Worker): _____

Date of Examination: _____

MEDICAL EVALUATION:

1) Diagnosis(s) or Impression:

2) Descriptive statement of medical condition(s):

REMARKS:

MEDICAL STATEMENT:

A. Does this individual's medical condition prevent them from working?

NO **YES** If yes, is this situation:

Temporary (If temporary, condition will improve in): _____ (months)
 Persistent (not able to work for 12 mos. or more)

If condition is persistent has it existed for 12 months or more?: | 1 yes | 1 no | Insufficient information to make determination

| 1 Other: (Explain)

B. In relation to the medical condition(s), the patient retains the capacity to:

- Occasionally** lift and/or carry (including upward pulling) for up to 1/3 of an 8-hour workday a maximum of:
 less than 10 pounds 10 pounds 20 pounds 50 pounds 100 pounds cannot assess
- Frequently** lift and/or carry from 1/3 to 2/3 of an 8-hour workday a maximum of:
 10 pounds 25 pounds 50 pounds cannot assess
- Stand and/or walk:**(with normal breaks) for a total of:
 less than 2 hours in an 8 -hour workday at least 2 hours in an 8-hour workday
 about 6 hours in an 8-hour workday cannot assess
- Sit** (with normal breaks) for a total of:
 less than about 6 hours in an 8-hour workday about 6 hours in an 8-hour workday cannot assess

C. Does the patient have other physical limitations related to the medical condition(s)?

NO **YES** If yes, please describe any other significant physical limitations such as postural, manipulative, environmental, visual, aural, speech, drug or alcohol abuse/dependency. _____

D. I recommend that patient be referred for an evaluation of behavioral health conditions that may prevent them from being able to work.

NO **YES** If yes, please state reason. _____

Alcohol and Other Drugs

Alcoholism: Yes No Probable (Explain) _____
Recovering Alcoholic: Yes No Probable (Explain) _____
Drug Abuse: Yes No Probable (Explain) _____
Recovering Drug Abuser: Yes No Probable (Explain) _____

Doctor's Name (Please Print) _____

Specialty _____

Doctor's Signature _____

Address _____

Physician's License# (required) _____

Date _____

Telephone Number _____

Fax Number _____

If the person completing this form is not a medical doctor, please sign below:

Name (Please Print) _____

Title (Please Print) _____

Signature _____

~~~~~  
I authorize release of requested information from my record for the use of the Alameda County Social Services Agency. I know this authorization may be used by the Alameda County Social Services Agency for up to one year from this date to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the agency. This information is needed to determine eligibility for cash aid or food stamps. It is also needed to decide the type of work or training activities that I can participate in. I have read this form (or had this form read to me) before I signed my name. I know I can get a copy of this form if I ask for it.

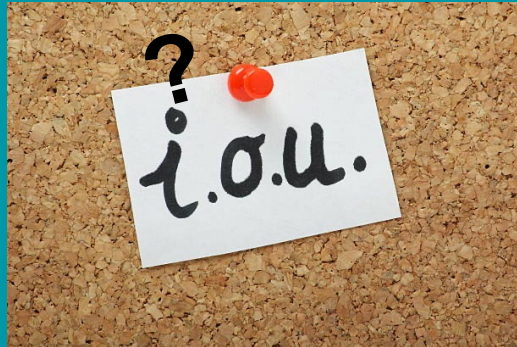
Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

# Do I have to pay GA back?

-Yes, sort of. GA payments are loans. Most counties require you to sign an agreement that you will repay it when your financial situation improves.

-If you become eligible for SSI benefits because of a disability, the county can repay itself for GA benefits it paid to you from your SSI back payment.



# GA Troubleshooting

## Solving problems:

- Call worker, if you have a recent notice it should be listed in the top right.
- File a hearing request found on notice of action and fax to (510) 777-2699, or client can contact HAC for assistance ASAP\*.
- EBT lost/stolen or to change PIN call (877) 328-9677.
- To check balance, status, and grant amount: use the [BenefitsCal.com](https://www.benefitscal.com) website.
- Fraud investigations - contact Alameda County Public Defender as these can be serious

# Homeless Action Center

Open Monday-Thursday 1pm - 5pm (510) 775-0035

West Oakland: 2601 San Pablo Ave., Oakland, CA 94612

Berkeley: 3126 Shattuck Ave., Berkeley, CA 94705

-Drop-Ins Welcome

-Attorneys or Advocates Available by Phone

-No Referrals or Appointments Necessary

Joe Baskin [jbaskin@homelessactioncenter.org](mailto:jbaskin@homelessactioncenter.org) (510) 457-1257

HAC Outreach Team [outreach@homelessactioncenter.org](mailto:outreach@homelessactioncenter.org)