KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

AVAILABILITY STATEMENT

K-BEN 32 (Rev. 9-18)

MAIL: Unemployment Contact Center
P.O. Box 3539
Topeka, KS 66601-3539
FAX: (785) 296-3249
EMAIL*: KDOL.UICC@ks.gov

*See important email notice on website.

Claimant Name: SSN: XXX-XX-

Complete this form and return it within **seven days** of the date you filed your claim**. Failure to reply by this date may result in a denial of benefits or possible overpayment.**

Are you looking for and willing to accept full-time work? ☐ YES ☐ NO If NO, explain: _____

_____

How many hours per week, on average, did you work in the last 18 months? _____

What type of work are you seeking? _____

Do you have training or experience in this type of work? ☐ YES ☐ NO If YES, how much? _____

What days of the week are you willing and available to work for at least eight hours of work?

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

If you indicated fewer than five days, explain: _____

How many miles are you willing to travel for work? _____

What is the lowest hourly wage you will accept? $ _____

List the work search activities you performed **last week** (Sunday through Saturday):

	Date	Employer name/address or type of activity	Job sought	Result of activity
Application				
Application 2				
Other Activity				

If you did not make any work search activities last week, explain: _____

_____

_____

Claimant name:	SSN: XXX-XX-

You indicated you have limitations that may prevent you from accepting work or may limit your availability to work. **Complete each section below that applies to you.** You may attach additional pages or documents if necessary.

☐ **Incarceration**

Date your incarceration began: _____ Date you were released: _____

☐ **Out of town/area/state**

To where did you travel? _____

Reason for travel: _____

Date you left home: _____ Return date: _____

☐ **Primary Care Giver**

For whom are you acting as a primary care giver? _____

Can you work full time while still providing care for that individual? ☐ YES ☐ NO

If NO, could anyone else provide care if you are offered a full-time job? ☐ YES ☐ NO

Name of alternate care giver: _____

Phone of alternate care giver: _____

Date you began acting as primary care giver: _____

☐ **Transportation**

Date you lost access to transportation: _____

Have you regained access to transportation? ☐ YES ☐ NO If YES, provide the date: _____

☐ **Other or Personal Reasons**

Describe the other or personal reasons for why you were unavailable for work: _____

_____

_____

Date you became unavailable: _____

Are you still unavailable for this reason? ☐ YES ☐ NO If NO, date unavailability ended: _____

CERTIFICATION: I certify that the information I have provided is correct and complete, and I understand the willful or intentional misrepresentation or failure to disclose a material fact is punishable under the Kansas Employment Security Law.

Signature: _____ Date: _____

Phone: _____ Email: _____

Submit