No. 5043374

25-6430

ORIGINAL

IN THE

SUPREME COURT OF THE UNITED STATES

FILED
DEC 31 2024
OFFICE OF THE CLERK
SUPREME COURT, U.S.

JESSE HOLLIDAY — PETITIONER
(Your Name)

VS.

STATE of CALIFORNIA — RESPONDENT(S)

MOTION FOR LEAVE TO PROCEED *IN FORMA PAUPERIS*

The petitioner asks leave to file the attached petition for a writ of certiorari without prepayment of costs and to proceed *in forma pauperis.*

Please check the appropriate boxes:

☑ Petitioner has previously been granted leave to proceed *in forma pauperis* in the following court(s):

PLACER COUNTY SUPERIOR COURT, ROSEVILLE, CALIF.

☑ Petitioner has **not** previously been granted leave to proceed *in forma pauperis* in any other court.

☑ Petitioner's affidavit or declaration in support of this motion is attached hereto.

☐ Petitioner's affidavit or declaration is **not** attached because the court below appointed counsel in the current proceeding, and:

☐ The appointment was made under the following provision of law: _____, or

☐ a copy of the order of appointment is appended.

Jesse Holliday
(Signature)

AFFIDAVIT OR DECLARATION
IN SUPPORT OF MOTION FOR LEAVE TO PROCEED *IN FORMA PAUPERIS*

I, JESSE JOSH HOLLIDAY, am the petitioner in the above-entitled case. In support of my motion to proceed *in forma pauperis*, I state that because of my poverty I am unable to pay the costs of this case or to give security therefor; and I believe I am entitled to redress.

1. For both you and your spouse estimate the average amount of money received from each of the following sources during the past 12 months. Adjust any amount that was received weekly, biweekly, quarterly, semiannually, or annually to show the monthly rate. Use gross amounts, that is, amounts before any deductions for taxes or otherwise.

Income source	**Average monthly amount during the past 12 months**		**Amount expected next month**	
	You	Spouse	You	Spouse
Employment	$ 0	$ N/A	$ 0	$ N/A
Self-employment	$ 0	$ N/A	$ 0	$ N/A
Income from real property (such as rental income)	$ 0	$ N/A	$ 0	$ N/A
Interest and dividends	$ 0	$ N/A	$ 0	$ N/A
Gifts	$ 0	$ N/A	$ 0	$ N/A
Alimony	$ 0	$ N/A	$ 0	$ N/A
Child Support	$ 0	$ N/A	$ 0	$ N/A
Retirement (such as social security, pensions, annuities, insurance)	$ 566	$ N/A	$ 0	$ N/A
Disability (such as social security, insurance payments)	$ 406	$ N/A	$ 0	$ N/A
Unemployment payments	$ 0	$ N/A	$ 0	$ N/A
Public-assistance (such as welfare)	$ 0	$ N/A	$ 0	$ N/A
Other (specify): _____	$ 0	$ N/A	$ 0	$ N/A
Total monthly income:	$ 972	$ N/A	$ 0	$ N/A

2. List your employment history for the past two years, most recent first. (Gross monthly pay is before taxes or other deductions.)

Employer	Address	Dates of Employment	Gross monthly pay
SELF	P.O. BOX 781035 ORLANDO, FL. 32878	2020 - 2022	$ 650
			$
RETIRED from	All WORK SITE	2022	$

3. List your spouse's employment history for the past two years, most recent employer first. (Gross monthly pay is before taxes or other deductions.)

Employer	Address	Dates of Employment	Gross monthly pay
N/A			$
			$
			$

4. How much cash do you and your spouse have? $ 17 (ME ONLY)
Below, state any money you or your spouse have in bank accounts or in any other financial institution.

Type of account (e.g., checking or savings)	Amount you have	Amount your spouse has
CHECKING	$ 17	$ N/A
	$	$
	$	$

5. List the assets, and their values, which you own or your spouse owns. Do not list clothing and ordinary household furnishings.

☐ Home
Value 0

☐ Other real estate
Value 0

☐ Motor Vehicle #1
Year, make & model 1999 CHRYSLER VAN
Value 1,000

☐ Motor Vehicle #2
Year, make & model N/A
Value

☐ Other assets
Description Laptop
Value $175

6. State every person, business, or organization owing you or your spouse money, and the amount owed.

Person owing you or your spouse money	Amount owed to you	Amount owed to your spouse
NONE	$ 0	$ N/A
	$	$
	$	$

7. State the persons who rely on you or your spouse for support. For minor children, list initials instead of names (e.g. "J.S." instead of "John Smith").

Name	Relationship	Age
NONE		

8. Estimate the average monthly expenses of you and your family. Show separately the amounts paid by your spouse. Adjust any payments that are made weekly, biweekly, quarterly, or annually to show the monthly rate.

	You	Your spouse
Rent or home-mortgage payment (include lot rented for mobile home) Are real estate taxes included? ☐ Yes ☑ No Is property insurance included? ☐ Yes ☑ No	$ 400	$ N/A
Utilities (electricity, heating fuel, water, sewer, and telephone)	$ 50	$ N/A
Home maintenance (repairs and upkeep)	$	$ N/A
Food	$ 140	$ N/A
Clothing	$	$
Laundry and dry-cleaning	$	$ N/A
Medical and dental expenses	$ 22	$

	You	Your spouse
Transportation (not including motor vehicle payments)	$ 70	$ N/A
Recreation, entertainment, newspapers, magazines, etc.	$ 0	$ N/A
Insurance (not deducted from wages or included in mortgage payments)		
Homeowner's or renter's	$ 0	$ N/A
Life	$ 0	$ N/A
Health	$ 0	$ N/A
Motor Vehicle	$ 84	$ N/A
Other: _____	$ 0	$ N/A
Taxes (not deducted from wages or included in mortgage payments)		
(specify): _____	$ 0	$ N/A
Installment payments		
Motor Vehicle	$ 0	$ N/A
Credit card(s)	$ 137	$ N/A
Department store(s)	$ 0	$ N/A
Other: _____	$ 0	$ N/A
Alimony, maintenance, and support paid to others	$ 0	$ N/A
Regular expenses for operation of business, profession, or farm (attach detailed statement)	$ 0	$ N/A
Other (specify): _____	$ 0	$ N/A
Total monthly expenses:	$ 903	$ N/A

9. Do you expect any major changes to your monthly income or expenses or in your assets or liabilities during the next 12 months?

☐ Yes ☑ No If yes, describe on an attached sheet.

10. Have you paid – or will you be paying – an attorney any money for services in connection with this case, including the completion of this form? ☐ Yes ☑ No

If yes, how much? N/A

If yes, state the attorney's name, address, and telephone number:

11. Have you paid—or will you be paying—anyone other than an attorney (such as a paralegal or a typist) any money for services in connection with this case, including the completion of this form?

☐ Yes ☑ No

If yes, how much? N/A

If yes, state the person's name, address, and telephone number:

N/A

12. Provide any other information that will help explain why you cannot pay the costs of this case.

TOO POOR, I BARELY SUBSIST ON less than the poverty level for 1 PERSON AND AM PARTIALLY-DISABLED

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: May 13, , 20 25

Jean Holliday
(Signature)

Form SSA-

SOCIAL SECURITY
5520 GATLIN AVE
SUITE 101
ORLANDO FL 32812

Social Security Administration
Supplemental Security Income
Notice of Change in Payment

Date: November 26, 2017
Claim Number: 547-70-5654 AI

000018305 I=000000 1119 4 COL

18295 1 AB 0.400

657 17S1038D71838
JOSH HOLLIDAY
PO BOX 781035
ORLANDO FL 32878-1035

We plan to increase your monthly Supplemental Security Income (SSI) payment from $311.00 to $317.00 beginning January 2018. The amount will change because the cost of living increased during the past year. You will continue to get the new amount each month unless there is a change in the information we use to figure your payment.

The rest of this letter explains more about your SSI payments. It also tells you how to find affordable health care.

We explain how we figured the monthly payment amount on the worksheet(s) at the end of this letter. The explanation shows how your income, other than any SSI payments, affects your SSI payment. We include explanations only for months where payment amounts change.

When You Will Receive Your Payments

Your bank or other financial institution will receive your monthly payment of $317.00 around January 1, 2018, and on the first of each month after that.

Information Used In Making The Decision

Our records show that the following income used to figure your payment has also changed--

Your increased Social Security benefits--before any deductions for Medicare premiums-- of $453.00. You should receive the increased Social Security benefit about January 3, 2018. We must count the increase in your benefits for January 2018 even though we are counting your other income for November 2017.

See Next Page

Your New Benefit Amount

12/18/19

BENEFICIARY'S NAME: JOSH HOLLIDAY

Your Social Security benefits will increase by **1.6%** in 2020 because of a rise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent, or energy assistance. You can also use it to apply for bank loans or for other business. Keep this letter with your important financial records.

How Much Will I Get And When?

• Your monthly amount (before deductions) is	$473.00
• The amount we deduct for Medicare Medical Insurance is (If you did not have Medicare as of November 22, 2019, or if someone else pays your premium, we show $0.00.)	$0.00
• The amount we deduct for your Medicare Prescription Drug Plan is (We will notify you if the amount changes in 2020. If you did not elect withholding as of November 1, 2019, we show $0.00.)	$0.00
• The amount we deduct for voluntary Federal tax withholding is (If you did not elect voluntary tax withholding as of November 22, 2019, we show $0.00.)	$0.00
• After we take any other deductions, you will receive on or about January 3, 2020.	$473.00

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. Or visit ***www.ssa.gov/non-medical/appeal*** to appeal online. We would be happy to review the amounts.

If you receive a paper check and want to switch to an electronic payment, please visit the Department of the Treasury's Go Direct website at ***www.godirect.org*** online.

What If I Have Questions?

- Visit our website at ***www.socialsecurity.gov***
- Call us toll-free at **1-800-772-1213** (TTY **1-800-325-0778**)
- Contact your nearest Social Security office

SSI – 317
SOC. SEC. – 473
$790 TOTAL

UPDATE MAY 16 2025

MY TWO CHECKS COMBINED TOTAL ABOUT $940 NOW

Jas Holliday
May 16/2025

STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES - DIVISION OF MOTORIST SERVICES

APPLICATION FOR DISABLED PERSON PARKING PERMIT

*********SUBMIT APPLICATION TO YOUR LOCAL COUNTY TAX COLLECTOR'S OFFICE OR LICENSE PLATE AGENCY*********
www.flhsmv.gov/offices/

Please Print/Type below

APPLICATION BY DISABLED PERSON (See Warning Below)

I certify that I am a person with one of the disabilities listed in section 320.0848, Florida Statutes. I further state that my physician or other certifying practitioner has completed the statement of certification below on my behalf, as required in section 320.0848, Florida Statutes.

Holliday, Josh Name of Disabled Person as printed on their Florida Driver License or Florida ID Card			Signature of Disabled Person or Guardian of the Disabled Person	
Date of Birth: 03/14/1947	Sex: M	Disabled Person's E-mail Address: HollidayJosh33@gmail.com		Date Signed: FEB 03 2012
Address: 2820 Alafaya Trail		City: Orlando	State: FL	Zip: 32826
Florida Driver License or Florida ID Number: (Required for permanent and temporary parking permits unless exception is noted by physician below) H430-420-47-094-0			If applicable, check one of the following: ☐ I am a frequent traveler. ☐ I am a quadriplegic.	

PHYSICIAN/CERTIFYING PRACTITIONER 'S STATEMENT OF CERTIFICATION (See Warning Below)

☒ **TEMPORARY PERMIT:** This is to certify that the applicant named above is a person with a temporary disability (six months or less) that limits or impairs his/her ability to walk or is temporarily sight impaired. Due to the temporary specific disability (ties) checked below (a-g), the disabled person parking permit should be issued from 11-1-11 (date) through 4-11-12 (date).

☐ **PERMANENT PERMIT:** This is to certify that the applicant named above is legally blind or is a disabled person with a permanent disability (ties) that limits or impairs his/her ability to walk 200 feet without stopping to rest. The specific disability (ties) type is/are checked below (a-g).

NOTE: "Unable to walk 200 feet" is no longer a qualifying disability, unless it is due to one of the conditions listed below (b-g).

DISABILITY TYPE:

☐ a. Legally Blind (This is the only disability an Optometrist can certify.)

☒ b. Inability to walk without the use of or assistance from a brace, cane, crutch, prosthetic device, or other assistive device, or without assistance of another person. If the assistive device significantly restores the person's ability to walk to the extent that the person can walk without severe limitation, the person is not eligible for the exemption parking permit.

☐ c. The need to permanently use a wheelchair.

☐ d. Restriction by lung disease to the extent that the person's forced (respiratory) expiratory volume for 1 second, when measured by spirometry, is less than one liter or the person's arterial oxygen is less than 60 mm/hg on room air at rest.

☐ e. Use of portable oxygen.

☐ f. Restriction by cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

☐ g. Severe limitation in a person's ability to walk due to an arthritic, neurological, or orthopedic condition.

WARNING: **Any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or 775.083, F.S. The penalty is up to one year in jail or a fine of $1,000 or both.**

Certification or License No. (Required) MD58878 of a Physician, Osteopathic or Podiatric Physician, Chiropractor, Optometrist, Advanced Registered Nurse Practitioner under the protocol of a licensed physician or a Physician Assistant licensed under Chapter 458 or 459.			LICENSED IN THE STATE OF FL
John Madlener, MD Print/Type Name of Certifying Authority	40 Alexandria Blvd. Ste 1020 Business Address	Orlando City:	State: FL	32765 Zip:
Certifying Authority Signature	Date Signed: 2-3-12		407-359-0047 (Area Code)Telephone Number	

☐ **SPECIAL EXCEPTION:** The severely disabled applicant named above applying for a permanent placard is unable to obtain a Florida driver license or identification card.
If the Special Exception box is checked, the certifying physician must provide his/her signature and date signed below.
If the Special Exception box is checked, one of the conditions in boxes a-g above must also be checked.

Certifying Authority Signature:	Date Signed:

APPLICATION BY AN ORGANIZATION (See Warning Above)

This is to certify that _____ provides regular transportation service to disabled persons having disabilities that limit or impair their ability to walk or are certified to be legally blind.

Number of Vehicles in fleet for this purpose:	FEID NUMBER:	Organizations E-mail Address:	
Signature of Organization's Authorized Representative		Date Signed:	
Address:	City:	State:	Zip:

TAX COLLECTOR USE ONLY

Agency Personnel Processing this Application	County	Agency	Date