



CDSS

WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

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EDMUND G. BROWN JR.
GOVERNOR

September 10, 2013

ALL COUNTY LETTER 13-74

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CaWORKs PROGRAM SPECIALISTS
ALL CONSORTIUM PROJECT MANAGERS
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: CALFRESH: NEW (AND REVISED) FORMS FOR THE
SEMI-ANNUAL REPORTING (SAR) SYSTEM

REFERENCE: ASSEMBLY BILL (AB) 6 (Chapter 501, Statutes of 2011),
ALL COUNTY LETTER (ACL) 12-25; ACL13-08; ACL 13-
17

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

The ACL 12-25, dated May 17, 2012, issued new policy instructions to County Welfare Departments (CWDs) for the implementation of SAR in CalWORKs and CalFresh. This ACL is to transmit new and revised forms related to SAR implementation. The CWDs should begin using these forms upon implementation of the SAR system. Changes to required forms, other than adding the county name, logo and contact information must be approved by the California Department of Social Services (CDSS) prior to making the change.

CAMERA READY COPIES AND TRANSLATIONS

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access you may obtain these forms from the CDSS webpage at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

When all translations are completed per MPP Section 21-115.2, including Spanish forms, they are posted on an on-going basis on the CDSS webpage. Copies of the translated forms can be obtained at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

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For questions on translated materials, please contact Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the [GEN 1365-Notice of Language Services](#) and a local contact number.

The CWDs shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services shall be provided free of charge to the applicant/recipient. In the event that CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it. More information regarding translations can be found in MPP Section 21-115.

This ACL and other CDSS Letters and Notices are available on the internet at:
<http://www.dss.cahwnet.gov/lettersnotices/default.htm>

If you have any questions regarding this letter, please contact your CalFresh county consultant or call the CalFresh Policy Bureau at (916) 654-1896.

Sincerely,

Original Document Signed By:

TODD R. BLAND
Deputy Director
Welfare to Work Division

Attachment

Attachment
CALFRESH FORMS FOR SEMI-ANNUAL REPORTING (SAR)

Form #	Form Title, Description, Explanation of Changes, and Directions for Use
CF 23 CR (08/13)	<p><u>CalFresh Benefits How to Report Household Changes (Required Form, Substitute Permitted)</u></p> <p>This form will replace the current version of the FS 23 upon implementation of SAR. This form is used to inform households of their reporting responsibilities. This form was updated to reflect reporting responsibilities for Change Reporting (CR) households and added a check box for counties to inform households that they are approved for benefits with CR status or have switched from SAR status to CR status.</p>
CF 286 SAR (08/13)	<p><u>CalFresh Budget Worksheet/Semi-Annual Reporting Households (Recommended Form)</u></p> <p>This form will replace the current version of the CF 285 SAR, initially issued in ACL 13-57, upon implementation of SAR. This form is used for CalFresh SAR cases. This form was updated to include a line in the budget for reasonably anticipated income. The form also separates the section of the worksheet related to averaging income for use when averaging is required.</p>
CF 377.6 (08/13)	<p><u>Information/Verification Needed (Required Form, Substitute Permitted)</u></p> <p>This form will replace the current CF 377.6 upon implementation of SAR. The form was renamed and the NA Back 9 was removed as this form is not a notice of action. The purpose of this form is the same.</p>
CF 388 (08/13)	<p><u>CalFresh Notice of Restoration Approval (Required Form, Substitute Permitted)</u></p> <p>This form will replace the QR 2104 upon implementation of SAR. The purpose of this form is the same. This form was updated to change all references of Food Stamps to CalFresh.</p>

CALFRESH BENEFITS

HOW TO REPORT HOUSEHOLD CHANGES

Everyone who receives CalFresh benefits must report when their income or household situation changes. If you're not sure how to report changes, what changes to report, or what proof we need, be sure to ask your worker. You are receiving this notice because:

- You have been approved for CalFresh benefits and will be reporting changes on a Change Reporting basis.
- Your household was previously assigned Semi-Annual Reporting status and will now be reporting on a Change Reporting basis.

Change Reporting requirements are described below.

CHANGE REPORTING

You **MUST** report the following changes within ten days:

- If your household has a change in the source of monthly earned income, or your household's monthly earned income starts, stops, or changes by more than \$100.00.
- If your household has a change in the source of monthly unearned income, or your household's monthly unearned income starts, stops, or changes by more than \$50.00.
- Anyone's source of income changes.
- You move in with someone else or anyone moves into or out of your home, including newborns, other children, spouses, other relatives or non-relatives.
- Anyone moves to another address, plans to move or gets a new mailing address.
- Your household's total cash, stocks, bonds or other money is more than \$2000 (or \$3250 if someone in your household is age 60 or over or disabled).
- If there is a change in the amount of any court ordered child support paid by a member of the household for a child not living in the home.
- If you are meeting the Able Bodied Adult Without Dependents (ABAWD) work rule by working and your work hours drop below 20 hours a week or 80 hours a month. CalFresh rules limit the receipt of CalFresh benefits to 3 months in a 3-year period for ABAWDs who are not working or participating in other allowable activities. You are excused from the ABAWD work rule and do not need to report a drop in your work hours if you are:
 - Living in a county where the ABAWD work rule is waived because of high unemployment rates;
 - Under 18 or 50 years of age or older;
 - Medically certified as physically or mentally unfit for employment'
 - Meeting the CalWORKs Welfare-To-Work rules
 - Caring for an injured or sick person who will need help for more than 30 days;
 - Participating in an alcohol or drug treatment program that keeps you from working 30 hours or more per week;
 - Getting or have applied for Unemployment Insurance benefits;
 - Employed or self-employed at least 30 hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours;
 - Going to school at least half-time;
 - Pregnant; or
 - Living in a CalFresh household that contains a minor child even if the minor child is not eligible for CalFresh benefits.
- If, since your last report, anyone in your home has been avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or is in violation of probation or parole.
- If, since your last report, anyone in your home has been convicted after August 22, 1996 of a drug-related felony for manufacturing, sale, or distribution of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities.

You **MAY** report when:

- Anyone's physical or mental illness begins or ends.
- Anyone's citizenship, immigration status changes or anyone gets a letter, form or new card from the U.S. Citizenship and Immigration Services (USCIS) (formerly INS).
- You have changes in your dependent care costs.
- Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.
- Any member begins to pay court-ordered child support for a child not living in the home.

You may report changes either:

- By mail, telephone, or in person at the County CalFresh Office; or
- By turning in a CF 377.5 CR CalFresh Household Change Report form.

TRANSITIONAL CALFRESH BENEFITS

California's Transitional CalFresh program provides CalFresh benefits for five months to households that leave CalWORKs. If your household begins receiving transitional CalFresh benefits, you do not have to report while receiving these benefits.

If you are receiving transitional CalFresh benefits, you may reapply to see if you can get more benefits. If you reapply and are approved for regular CalFresh benefits, then all normal reporting rules will apply.

CALFRESH BUDGET WORKSHEET/SEMI-ANNUAL REPORTING HOUSEHOLDS

CASE NAME	COMPANION CASE REFERENCE	CASE NUMBER	CLASSIFICATION <input type="checkbox"/> NA <input type="checkbox"/> PA <input type="checkbox"/> MIXED <input type="checkbox"/> TC
CERTIFICATION PERIOD FROM _____ THROUGH _____	BUDGET IS BASED ON: SAR 7 <input type="checkbox"/>	MID-CERTIFICATION PERIOD REPORT <input type="checkbox"/>	OTHER <input type="checkbox"/> RECERTIFICATION <input type="checkbox"/>

INSTRUCTIONS:

List the amount of Reasonably Anticipated Income on line 1a. Reasonably Anticipated Income is the specified amount of monthly income the household and CWD are reasonably certain the household will receive in the SAR payment period. Use the worksheet under 1b to average income for those households that elect to or are required to have their income averaged.

PART 1 - GROSS INCOME

A. NONEXEMPT GROSS UNEARNED INCOME

1a. Reasonably Anticipated Income \$ _____

1b. Income Averaging (use worksheet below)

	SOCIAL SECURITY, UIB, DIB, PENSIONS	CHILD/SPOUSAL SUPPORT	SCHOLARSHIPS, GRANTS, LOANS	OTHER
Month 1/Year _____ / _____	\$ _____	\$ _____	\$ _____	\$ _____
Month 2/Year _____ / _____	\$ _____	\$ _____	\$ _____	\$ _____
Month 3/Year _____ / _____	\$ _____	\$ _____	\$ _____	\$ _____
Month 4/Year _____ / _____	\$ _____	\$ _____	\$ _____	\$ _____
Month 5/Year _____ / _____	\$ _____	\$ _____	\$ _____	\$ _____
Month 6/Year _____ / _____	\$ _____	\$ _____	\$ _____	\$ _____
Total Unearned Income				\$ _____
Averaged Gross Unearned Income (total unearned + number of month)				\$ _____

- 2. Monthly Income Amount From 1a (or 1b if appropriate) \$ _____ (A2)
- 3. Cash Aid \$ _____ (A3)
- 4. Less Child Support Paid (enter any remainder in B3) \$ _____ (A4)
- 5. Total Gross Unearned Income (A2 + A3 - A4) **Total** \$ _____ (A5)

B. NONEXEMPT GROSS EARNED INCOME

1a. Reasonably Anticipated Income \$ _____

1b. Income Averaging (use worksheet below)

	GROSS SALARY/WAGES	SELF EMPLOYMENT	TRAINING ALLOWANCES
Month 1/Year _____ / _____	\$ _____	\$ _____	\$ _____
Month 2/Year _____ / _____	\$ _____	\$ _____	\$ _____
Month 3/Year _____ / _____	\$ _____	\$ _____	\$ _____
Month 4/Year _____ / _____	\$ _____	\$ _____	\$ _____
Month 5/Year _____ / _____	\$ _____	\$ _____	\$ _____
Month 6/Year _____ / _____	\$ _____	\$ _____	\$ _____
Total Gross Earned Income			\$ _____
Averaged Gross Unearned Income (total gross earned income + number of months)			\$ _____

- 2. Monthly Income Amount From 1a (or 1b if appropriate) \$ _____ (B2)
- 3. Less Remainder of Child Support Paid (if not fully used in Section A) \$ _____ (B3)
- 4. Total Gross Earned Income (B2 - B3) **Total** \$ _____ (B4)

PART 2 - GROSS INCOME

C. GROSS INCOME TEST FOR HOUSEHOLDS WITH NO ELDERLY OR DISABLED MEMBERS

- 1. Maximum Gross Income allowed for Household Size of _____ (from table) \$ _____
- 2. Total Gross Income (A5 + B4) = \$ _____
- 3. Gross Income Eligible? (Is C2 less than or equal to C1?) YES NO

PART 3 - NET INCOME**D. NONEXEMPT GROSS INCOME**

- 1. Gross Earned Income (B2) \$ _____
- 2. Adjusted Gross Earned Income (80% of D1) \$ _____
- 3. Less Remainder of Child Support Paid (B3)
(if not fully used in Section A) \$ _____
- 4. Total Gross Earned Income (D2 - D3)
(If negative amount, enter zero) \$ _____
- 5. Total Gross Unearned Income (A5) \$ _____
- 6. Nonexempt Gross Income (D4 + D5) \$ _____

E. STANDARD

Standard Deduction \$ _____

F. DEPENDENT CARE (100% OF COSTS)

\$ _____

G. HOMELESS SHELTER DEDUCTION

\$ _____

H. TOTAL DEDUCTIONS (E + F + G)

\$ _____

I. ADJUSTED NET INCOME

- 1. Nonexempt Gross Income (D6) \$ _____
- 2. Total Deductions (Line H) \$ _____
- 3. Adjusted Net Income (I1 - I2) \$ _____

J. SHELTER DEDUCTION

- 1. Total Housing Costs \$ _____
- 2. Total Utility Allowance \$ _____
- 3. Total Shelter costs \$ _____
- 4. Allowable Shelter costs (50% of I3) \$ _____
- 5. Excess Shelter costs (J3 - J4) \$ _____
- 6. Maximum Allowance For Shelter \$ _____
- 7. Allowable Shelter Deduction (Lesser of J5 or J6) \$ _____

K NET MONTHLY INCOME (I3 - J7)

\$ _____

L. NET INCOME TEST

- 1. Household Size _____
- 2. Maximum Net Income Allowable (from table) \$ _____
- 3. Net Income eligible YES NO

PART 4—INCOME COMPUTATIONS**PAYMENT PERIOD****M. SELF-EMPLOYMENT (Nonexempt Resources Only)**

- 1. Gross Income from Self-Employment \$ _____
- 2. Expenses: Standard 40% Deduction
 Actual Expenses (Verification Required) \$ _____
- 3. Total Nonexempt Income from Self-Employment (M1 - M2) \$ _____
If averaging self-employment income go to M7. If adjusting a previous average, continue to M4.
- 4. Adjustment to Gross Income \$ _____
- 5. Adjustment to Expenses \$ _____
- 6. Adjusted Self-Employment Income (M3 + M4 + M5) \$ _____
- 7. Monthly Self-Employment Income (M3 or M6 ÷ number of months income covers) \$ _____

N. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS**PAYMENT PERIOD**

- 1. Income from Grants, Scholarships or Loans \$ _____
- 2. Tuition and Mandatory Fees \$ _____
- 3. Total Nonexempt Educational Income (N1 - N2) \$ _____
- 4. Monthly Income from Grants, Scholarships or Loans (N3 ÷ number of months income covers) \$ _____

PART 5—REPORTED CHANGES (Other than the SAR 7 or CF 377.5 SAR)

Type of Change					
Date Change Occurred					
Date Change Reported					
EW Initials					

INFORMATION/VERIFICATION NEEDED

Notice Date: _____

Case Name: _____

Case Number: _____

Worker Name: _____

Worker Number: _____

Telephone Number: _____

Worker Hours: _____

Address: _____

We recently received information about a change in your household. We need your help to figure out if this change will affect your benefits. We want you to have all the benefits for which you qualify. You will get a notice if this lowers or ends your benefits.

- You reported a change that could increase your benefits for the next month. To be sure your next benefits are right, please return the items listed below to us by _____. Please let us know before this date, if you need more time to return these items. If the listed items are received after this date, any increase in benefits will be delayed. If you need help getting any of these items, you can contact your county CalFresh office.

CALFRESH NOTICE OF RESTORATION APPROVAL

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____

(ADDRESSEE)

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Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

YOUR CALFRESH BENEFITS HAVE BEEN RESTORED EFFECTIVE _____. This is the date we got the needed information to restore your benefits. Your certification remains the same and ends on _____.

If nothing changes you will get:

\$ _____ for _____ for _____ people.
\$ _____ for _____ for _____ people.
\$ _____ for _____ for _____ people.

COMMENTS:

Rules: These rules apply: ACL #10-32
You may review them at your welfare office.