
**FISCAL MANAGEMENT AND CONTROL
GENERAL ADMINISTRATIVE RESPONSIBILITIES**

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CHAPTER 25-600 FORMS

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25-600 MANDATORY AND RECOMMENDED FORMS USED IN OR AFFECTING FISCAL FUNCTIONS**25-600**

The following SDSS forms are mandatory, except for those marked * which are recommended only. If mandatory forms are not suitable to special mechanical equipment of a county, forms designed by the county, adapted to such mechanical use, may be used in lieu thereof upon prior written approval of SDSS. Such forms, to be approved, must accomplish the purposes and provide all of the data required on mandatory forms.

Wherever possible in each of the following nine (9) categories of forms, parenthetical reference is made in the category title to that chapter in Division 25 of the Manual of Policies and Procedures which contains general information relating to the area of activity of the forms in that category.

FORM NUMBER**I. AUTHORIZATION AND AUTHORIZATION CONTROL (see Chapter 25-200)**

ABCD 278L	List of Authorizations to Start, Change or Stop Aid Payments
ABCD 278M	Authorizations to Start, Change or Stop Aid Payments
*ABCD 821	Batch Voucher of Individual County Authorizations
*ABCD 822	Register of County Authorizations

II. AID CLAIMS (see Chapter 25-700)**A. Monthly Claims**

ABCD 801	Aid Payroll (Contra Roll)
ABCD 820	Reconciliation Statement, County Authorizations to Auditor's Payments
AD 800A	Summary Report of Assistance Expenditures-Adoption Assistance Program/Federal
AD 800B	Summary Report of Assistance Expenditures-Adoption Assistance Program/Nonfederal (includes Aid for the Adoption of Children-AAC)
CA 800	Summary Report of Assistance Expenditures-Aid to Families with Dependent Children
CA 800 FC (FED)	Summary Report of Assistance Expenditures-Federal Children in Foster Care
* CA 800 FC.1 (FED)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from Federal Funds
* CA 800 FC.2 (FED)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from State Funds
CA 800A FC (NONFED)	Summary Report of Assistance Expenditures-Nonfederal Children in Foster Care
DFA 843	Federal Funds Claimable Based on the Expenditures for Refugee Resettlement, Cuban Program Phasedown and Cuban/Haitian Entrant Recipients in Receipt of Nonfederal AFDC-FC
DFA 844 RDP	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Demonstration Project Recipients (RDP)
DFA 847	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement, Cuban Program Phasedown and Cuban/Haitian Entrant Recipients in Receipt of Federal AFDC-FC
DFA 859	Federal Funds Claimable Based on Expenditures for Time Eligible Refugees and Entrants in Receipt of General Assistance
DFA 863	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement and Cuban/Haitian Entrant Recipients in Receipt of Emergency Assistance-Unemployed Parent

FISCAL MANAGEMENT AND CONTROL**25-600 (Cont.)****FORMS****Handbook**

25-600 MANDATORY AND RECOMMENDED FORMS USED IN OR AFFECTING FISCAL FUNCTIONS (Continued) 25-600

- | | |
|---------|--|
| SC 800 | Summary Report of Special Circumstances |
| SOC 800 | Summary Report of Assistance Expenditures Emergency Assistance- Foster Care |
| SOC 801 | Summary Report of Assistance Expenditures Emergency Assistance-Unemployed Parent |
- B. Quarterly Claims
- | | |
|---------|---|
| AD 800 | Certification - Adoption Cost of Care Subvention Under W&IC 16106 |
| AD 801A | Adoption Cost of Care Claim (W&I Code Section 16106) |
| DFA 837 | Summary Report of Assistance Expenditures Old Age Security, Aid to the Blind, and Aid to the Disabled |
| EL 800 | Summary Report of Uncollected Loans (For Claiming Against the Emergency Revolving Fund) |
- C. (Deleted by Manual Letter No. FMC-86-04, effective 7/1/86.)
- D. (Deleted by Manual Letter No. FMC-86-04, effective 7/1/86.)

III. CLAIMS FOR ADMINISTRATIVE EXPENDITURES (See Chapter 25-800)

As the County Welfare Department Administrative Expense Claim is frequently modified due to program changes during the fiscal year, many of the individual form numbers and names are not identified below. The forms listed below are not displayed in Section 25-605 since they are subject to revision each quarter. Updates and current form numbers for the Administrative Expense Claim will be transmitted to the counties on a current basis via All-County Letter.

The Administrative Expense Claim is composed of the following form categories:

- | | |
|---------------|--|
| DFA 43 | Eligibility and Nonservice Time Study |
| DFA 46 | Social Services Time Study |
| DFA 47 | Social Services Time Study Summary and Program Allocations |
| DFA 48 | Electronic Data Processing Time Study (all other) |
| DFA 48A | Electronic Data Processing Time Study (statewide systems) |
| DFA 50 | Staff Development Time Study |
| DFA 52 | Employment Services Time Study |
| DFA 53 | Employment Services Time Study Summary and Program Allocations |
| DFA 323 | Eligibility and Nonservices Time Study Summary and Program Allocations |
| DFA 325.1 | Expenditures Schedule and Certification |
| DFA 325.1A | Electronic Data Processing Schedule (all other) |
| DFA 325.1AA | Electronic Data Processing Schedule (statewide systems) |
| DFA 325.1B | Direct Cost Schedule |
| DFA 327.1-.11 | Expenditures Distribution and Funding Pages |
| DFA 403 | Reconciliation of Time Studies to Allocable Salary Pools |
| DFA 419 | Claim Summary Sheet |
| DFA 856 | Welfare Fraud Time Study |

25-600 MANDATORY AND RECOMMENDED FORMS USED IN OR AFFECTING FISCAL FUNCTIONS (Continued) 25-600

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (see Section 25-950)

- CS 355 DA Employee's Child Support Time Study for IV-D Functions
- CS 356.1 IV-D Child Support Expenditure Schedule and Certification (front)
- CS 356.2 IV-D Child Support Expenditure Schedule and Certification (back)
- CS 356.3 IV-D Child Support Time Summary and Activity Allocation Ratios
- CS 356.4 IV-D Child Support Program Distribution, Total Allocable Costs
- CS 356.5 IV-D Child Support Program Distribution, Direct Costs
- CS 356.6 IV-D Child Support Program Distribution, Total Allocable and Direct Costs
- CS 356.7 IV-D Child Support Program Distribution Report of Total Expenditures
- CS 356.8 IV-D Child Support Program - Personal Services
- CS 357 Group A Individual Employee Worksheet, Local IV-D Agency - Direct Costs

VI. CHILD SUPPORT SPACE COST CLAIM REQUEST FORMS (Obsolete. Deleted by Manual Letter No. FMC-88-02, effective 9/1/88.)

VII. CHILD SUPPORT INCENTIVE CLAIMS (see Chapter 25-900)

- CS 278L Child and Spousal Support Case History and List of Authorizations
- CS 278M Child and Spousal Support Transmittal/Action Document
- CS 800 Summary Report of Child and Spousal Support Payments
- CS 801 Child and Spousal Support Payroll Form for Collections and Disbursement
- CS 801A Summary CS 800 Reconciliation - Intracounty/Interstate
- CS 801B Intercounty Summary CS 800 Reconciliation
- CS 820 Child/Spousal Support Collections Summary Report
- CS 821 Support Collection Report
- CS 822 Summary CS 820 Reconciliation Statement
- CS 831 Collection Agency - Accounts Receivable

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (see Chapter 25-400)

- * ABCD 830 Overpayment Receivable Record
- ABCD 831 Repayment Receivable Record

IX. MISCELLANEOUS FORMS

- GEN 215 Claim for Reimbursement - Local Agency Special Project (see Chapter 25-800)

*Suggested

- Form H Substitute Payee Certification
- GEN 127 Notice of Form Change

25-601 FORMS SUPPLY **25-601**

Forms developed for operation of the welfare programs will be printed by SDSS and made available to the county welfare departments and other agencies requiring their use.

SDSS will keep users informed of new and revised forms, where to order a supply, whether the form is free or sold, whether an initial supply is being sent and whether old issues of a revised form may be used.

SDSS will make available semiannually the County Forms Catalogue, listing free and sold forms available through the SDSS Warehouse.

25-602 RETENTION SCHEDULES **25-602**

State forms listed in Chapter 25-600 and their supporting records must be retained by the county as required by 23-353 unless notification has been received from SDSS that there are unresolved audit issues or that records must be retained for other needs of the department. The exceptions are:

1. ABCD 830 original shall be retained in the case record.
2. All DFA 117 forms shall be retained for the minimum period after disposal of the property.

This retention schedule is for fiscal purposes of SDSS and does not authorize the county to destroy any of these records which have a longer retention period required by other laws or regulations.

25-605 FORMS

25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (see Chapter 25-200)

ABCD 278L

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

LIST OF AUTHORIZATIONS TO START, CHANGE, OR STOP AID PAYMENTS CASE NUMBER: _____

CASE NAME: _____ COUNTY: _____ DISTRICT: _____

PAYEE NAME AND ADDRESS (1): _____ PAYEE NAME AND ADDRESS (2): _____

I certify that the Statement of Facts Supporting Eligibility for Assistance is on file or that the facts have been verified by investigation; that the supporting evidence is open to inspection in the Department by duly authorized state and federal representatives; and that, to the best of my knowledge and belief, the action hereon approved was correct under existing law.

EFFECTIVE DATE	FED. PERS. COUNT		ADAPED PERS. COUNT		CONTINUING GRANT AMOUNT	SUPPLEMENTAL PAYROLL		TYPE OF ACTION REASON FOR CHANGE	APPROVED (INITIAL AND DATE)		AUTHORIZED BY DATE
	A	CH	A	CH		SUPPLEMENTAL AMOUNT	TOTAL AMOUNT		WORKER	SUPP.	

ABCD 278L (11/76) ADULT-SI CHILDREN-EP-ESSENTIAL PERSONS- TYPING SM-50

25-605 FORMS (Continued)

25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

Reverse of ABCD 278L

NAME	BIRTHDATE	APPLICATION DATE	RESTORATION SIGNED	REMARKS
ELIGIBLE				
RELATIVE				
ELIGIBLE				
RELATIVE				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
ESSENTIAL PERSON				
ESSENTIAL PERSON				
ESSENTIAL PERSON				

DATE	REPAYMENT AMOUNT	ABATEMENTS		REMARKS
		AMOUNT	MONTH APPLICABLE	

25-605 FORMS (Continued)

25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

ABCD 278M and Reverse

NAME, ADDRESS, CASE NO., PERSONS COUNT, CURRENT AUTHORIZATION										<input type="checkbox"/> AFDC <input type="checkbox"/> BH <input type="checkbox"/> AAC <input type="checkbox"/> APSE <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> SC <input type="checkbox"/> EL <input type="checkbox"/> CR <input type="checkbox"/> IRAP	
CHANGE PAYEE TO: NAME _____ STREET ADDRESS _____ CITY _____										I certify that the Statement of Facts Supporting Eligibility for Assistance is on file or that the facts have been verified by investigation; that the supporting evidence is open to inspection in the Department by duly authorized state and federal representatives; and that, to the best of my knowledge and belief, the action and amount specified are correct under existing law. AUTHORIZED BY THE COUNTY OF _____	
CHANGE CONTINUING GRANT											
EFFECT DATE	REG PERSONS COUNT	E P	NONREG PERSONS COUNT	CONTINUING GRANT AMOUNT	FIRST WARRANT AMOUNT	SECOND WARRANT AMOUNT	EXCESS OF STATE BASE	TYPE OF ACTION: REASON FOR CHANGE			CODE
ISSUE SUPPLEMENTAL WARRANT											
EFFECT DATE	REG PERSONS COUNT	E P	NONREG PERSONS COUNT	TOTAL GRANT	FIRST GRANT	WARRANT AMOUNT	EXCESS OF STATE BASE	TYPE OF ACTION: REASON FOR CHANGE			
STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY AUTHORIZATIONS TO START, CHANGE, OR STOP AID PAYMENTS DEPARTMENT OF SOCIAL SERVICES											
ABCD 278M (7-82)											

ABBREVIATION KEY	
A	Adult(s)
CH	Child(ren)
EP	Essential Person(s)
AFDC	Aid to Families with Dependent Children
BH	Boarding Homes and Institutions
AAC	Aid to the Adoption of Children
SC	Special Circumstances
EL	Emergency Loans
CR	Cuban Refugee
IRAP	Indo-Chinese Refugee Assistance Program

25-605 FORMS (Continued)

25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

ABCD 821

DEPARTMENT OF SOCIAL SERVICES

BATCH VOUCHER

OF INDIVIDUAL COUNTY AUTHORIZATIONS

PROGRAM _____ BATCH VOUCHER NO. _____

COUNTY ACTION DATE _____, 19__)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

To be filed in county available for audit.
Key: A - Adults; EP - Essential Persons
CH - Children

MONTH OF CLAIM () ()

Case Number (1)	Effective Date (2)	Change Authorizations Covering Grant Future Month		Authorizations Affecting Current and Prior Months					
		From (3)	To (4)	Current Month	Current Month		Prior Months		
		No. Issued (5)	No. Cancelled (6)	Issue Warrant (7)	Cancel Warrant (8)	Issue Warrant (7)	Cancel Warrant (8)	Issue Warrant (7)	Cancel Warrant (8)

ABCD 821 (9/78)

25-605 FORMS (Continued)

25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

Reverse of ABCD 821

INSTRUCTIONS

Form ABCD 821

Month of Claim. In space above "Future Month" section, show month following month of "County Action Date." In space above "Authorizations Affecting Current and Prior Months" section, show same month as "County Action Date."

Exception: If "County Action Date" falls between master payroll cut-off date and end of month show next subsequent month over "Future Month" section.

Example: County Action Date June 29. Master Payroll cut-off date June 27. In "Future Month" section show "August" as month of claim. In Current and Prior Month section:

- (a) Show June if warrant is to be written in June, or
- (b) Show July if warrant is to be written in July.

Column 1. Post case number from Form 278-M.

Column 2. Post "Effective Date" for future month from entry in "Change Continuing Grant" line of Form 278-M; for current and prior month from appropriate line in "Issue Supplemental Warrant" section.

Column 3. Post prior grant amount as shown in preprint section of Form 278-M.

Column 4. Post new continuing grant amount.

Column 5. Post amount of supplemental authorization for current month shown in "Warrant Amount" column of Form 278-M.

Column 6. Post amount of warrant for current month, or for prior month issued in current month, authorized to be canceled. (Shown in parenthesis in "Prior Grant" column of Form 278-M and/or in "Type of Action, Reason for Change.")

Column 7. Post amount of supplemental authorization for prior month shown in "Warrant Amount" column.

Column 8. Post amount of warrant for prior month issued in prior month authorized to be canceled.

Posting to "Register of County Authorizations" ABCD 822. Authorizations for both the current and the future month are posted to the same batch voucher. From this single batch voucher column totals are posted to current and future month "Registers of County Authorizations." Column totals from "Change Authorization -- Future Month" section are posted to the Register for the future month, and column totals from "Authorizations Affecting Current and Prior Months" section are posted to the current month Register.

Persons count. Entries made in column headed "PC" to the right of the money column represent changes in the eligible persons count: e.g., in an AFDC case added child increases eligible persons count in master deck from 3 to 4. Post "1" (not 4) in "PC" column beside the money entry in Column 4, showing that a count of 1 has been added to the previous total. Make no entry in "PC" Column 3.

Persons count entries will be made for new cases, restorations, added or discontinued child, adult or essential person in AFDC, discontinuances and cancellation of warrant. No persons count entry is to be made for a supplemental increase payment when a previously issued warrant remains in effect.

Enter in Column 6 (Cancel current month warrant) rather than Column 8 (Cancel prior month warrant) persons count for prior month warrant issued in current month authorized to be canceled.

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

ABCD 822

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

REGISTER OF COUNTY AUTHORIZATIONS
PROGRAM _____ MONTH _____ 19__

To be filled in county available for audit.

A-Adults
C1-Children
EP-Español Personal

BATCH VOUCHER NUMBER	COUNTY ACTION DATE	AUTHORIZATION CHANGES TO MASTER PARROLL		SUPPLEMENTAL PROGRAMS AND ACCOUNT CANCELATIONS AUTHORIZED																	
		AMOUNTS DELETED	PERSONS COUNT	AMOUNTS ADDED	PERSONS COUNT	CURRENT MONTH			PRIOR MONTHS			PERSON COUNT									
		A	Ca	EP	(4)	A	Ca	EP	(8)	A	Ca	EP	(1)	A	Ca	EP	(10)	A	Ca	EP	
11	EP	131		141																	

NOT INCLUDED IN RECONCILIATION STATEMENT. USE AS CONTROL
TO WARRANTS ACTUALLY CANCELED AND REPORTED ON CLAIM.

ABCD 822 (3/78)

**FISCAL MANAGEMENT AND CONTROL
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25-605 (Cont.)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (see Chapter 25-700)

A. Monthly Claims -- ABCD 801

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

AID PAYROLL (CONTRA ROLL)

PROGRAM _____

COUNTY _____										DATE (MO. YEAR)		
TYPE OF ROLL _____										WARRANTS DATED (EXCEPT AS SHOWN IN COLUMN 12)		
CASE NUMBER AND NAME	CODE	MONTH AND YEAR	FED PERSONS (COUNT)			E	NONFED PERSONS (COUNT)		TOTAL AID PAID	COUNTY SUPPL. AID (FATEL PG ONLY)	WARRANT NUMBER	REMARKS
			A	CH	P		A	CH				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	
PAGE TOTALS												

KEY

A—ADULT(S)
CH—CHILD(REN)
EP—ESSENTIAL PERSON(S)

ABCD 801 (3-78)
56245 REV 12-74 DTM:HRP

Page Number _____

CALIFORNIA-SDSS-MANUAL-FISCAL

CALIFORNIA-DSS-MANUAL-FMC

MANUAL LETTER NO. FMC-86-04

Effective 7/1/86

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- ABCD 820

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

**RECONCILIATION STATEMENT
COUNTY AUTHORIZATIONS TO AUDITOR'S PAYMENTS**

Program _____

County _____ Month of _____ 19__

INSTRUCTIONS

If persons counts in items 1 through 10 include nonfederal persons and essential persons. Item 12 must also include nonfederal persons and essential persons. Forward one copy with each monthly claim to Department of Social Services, 764 P Street, Sacramento 95814.

	AMOUNT	PERSONS COUNT
1. Continuing aid payments previously authorized in master deck control for previous month. (Item 4 of the reconciliation statement, Form ABCD 820, of the previous month) _____	\$ _____	_____
2. Less total of prior authorization amounts deleted from master deck control for this month. (Column 3 ABCD 822) _____	_____	_____
Subtotal _____	_____	_____
3. Plus total of new amounts authorized to be added to master deck control for this month. (Column 4 ABCD 822) _____	_____	_____
4. Net amount of authorized continuing aid payments in master deck control for this month. _____	_____	_____
<hr/>		
5. Plus current month supplemental warrants authorized. (Column 5 ABCD 822) ...	\$ _____	_____
6. Total amount of warrants authorized to be issued this month for this month.	_____	_____
7. Plus amount of aid authorized to be paid this month for prior months. (Column 7 ABCD 822) _____	_____	_____
8. Total amount of warrants authorized to be issued this month.	_____	_____
9. Less payments for current month and for prior months ISSUED THIS MONTH authorized to be canceled. (Column 6 ABCD 822).	_____	_____
10. Net total of aid authorized to be paid this month.	_____	_____
11. Amount claimed this month.	_____	_____
12. Persons claimed this month.	_____	_____
13. Difference, if any, between Items 10 and 11.	_____	_____
14. Difference, if any, between Items 10 and 12.	_____	_____

(Explain any differences below or on a separate sheet)

*ABCD 820 (2/78)

**FISCAL MANAGEMENT AND CONTROL
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25-605 (Cont.)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- AD 800A

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

SUMMARY REPORT OF ASSISTANCE EXPENDITURES - ADOPTION ASSISTANCE PROGRAM/FEDERAL For State Use DSS County Welfare County Auditor

COUNTY: _____ DATE: _____

A PERSONS COUNT	B AMOUNTS	SOURCE DOCUMENTS	
		1.	Main Payroll
		2.	Current Month Supplemental Payroll
() ()		3.	Current Month Cancellation Contra Roll
		5.	Prior Months Supplemental Payroll
		6.	Subtotal (reconciliation totals)
() ()		7.	Prior Months Cancellation Contra Roll
() ()		8.	Abatements and Repayments
		9.	Schedule of Adjustments (show minus items in parentheses)
		10.	Subtotals (Lines 7, 8, 9)
		11.	DSS Office Audit Corrections (for state use only)
		12.	TOTAL
		13.	Net payments not subject to 5 Federal funding
		14.	The amount in Line 13A subject to Federal funding
		C	
		15.	Line 12B minus Line 13A plus Line 14A x 5
		D	
		16.	Line 12B minus Line 15C

		C FEDERAL Error Line 15 C	D STATE Error Line 16D	
GRAND TOTALS	\$	\$	\$	17
(FOR STATE USE)		(Line 15C)	(Line 16D)	18
(FOR COUNTY USE)				19
A	CH			20
				21

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of the Adoption Assistance Program in and for the above county, that I have not violated any of the provisions of Sections 10300 to 10305, inclusive, of the Government Code, that the aid payments, adjustments for payments in kind, and repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

I HEREBY CERTIFY, under penalty of perjury, that I am the official in charge of county (RESPONSIBLE FOR THE EXAMINATION AND SETTLEMENT) OF ACCOUNTS, that I have not violated any of the provisions of Sections 10300 to 10305, inclusive, of the Government Code, that the amounts claimed herein are in accordance with authorizations for the Adoption Assistance Program made by the county, that said amounts correctly reflect Federal and State Shares on the aid payments claimed and that vouchers therefor have been issued or funds made available for the payments in kind as authorized by law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR _____ DATE _____ SIGNATURE OF COUNTY AUDITOR OR CHIEF CLERK _____ DATE _____

40 8009-110 83 TS-404

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of AD 800A

INSTRUCTIONS FOR USE OF FORM AD 800A

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with amounts shown on the integrated payroll or contra roll; Line 4 has been omitted from the form because there are no provisions to reduce grants to zero due to prior overpayments.
3. Enter the subtotals in Lines 6 and 10, and totals in Lines 12A and B.
4. Line 13A - For children receiving AAP payments in excess of the foster family home rate enter the total assistance payments (minus any cancellations, abatements, etc.).
5. Line 14A - Enter that amount in line 13A subject to 50 percent federal funding.
6. Line 15C - Subtract line 13A from line 12B, then add line 14A and multiply by .5 to determine 50 percent federal share.
7. Line 16D - Subtract line 15C from line 12B to determine the state share.
8. Line 17C - Enter line 15C.
9. Line 17D - Enter line 16D.
10. Lines 18 and 19 - Reserved for the application of adjustments made by the state (Federal and/or State Field Audit Exceptions, etc.).
11. Lines 20 and 21 - Included at county request and use is optional. If adjustments are reported in line 9 which effect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

AD 800A (Beck) Instructions (10/82)

**FISCAL MANAGEMENT AND CONTROL
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25-605 (Cont.)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- AD 800B

STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES	
SUMMARY REPORT OF ASSISTANCE EXPENDITURES - ADOPTION ASSISTANCE PROGRAM/ NONFEDERAL (INCLUDES AID FOR THE ADOPTION OF CHILDREN-AAC)		For State Use <input checked="" type="checkbox"/> DSS <input type="checkbox"/> County Welfare <input type="checkbox"/> County Auditor	
COUNTY		DATE MONTH, YEAR	
A	B	SOURCE DOCUMENTS	
PERSONS COUNT	AMOUNTS		
		1. Main Payroll	
		2. Current Month Supplemental Payroll	
		3. Current Month Cancellation Contra Roll	
		5. Prior Months Supplemental Payroll	
		6. Subtotal (reconciliation totals)	
		7. Prior Months Cancellation Contra Roll	
		8. Abatements and Repayments	
		9. Schedule of Adjustments (show minus items in parentheses)	
		10. Subtotals (Lines 7, 8, 9)	
		11. DSS Office Audit Corrections (for state use only)	
		12. TOTAL	
B		C	
		STATE	
GRAND TOTALS	\$	\$	13.
	(Line 12B)	(Line 12B)	
(FOR STATE USE)			14.
			15.
(FOR COUNTY USE)	DSS CTS	 	16.
		 	17.
I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of the Adoption Assistance Program in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, allotments for payments in kind, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.		I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for the Adoption Assistance Program made by the county; that said amounts correctly reflect the aid payments claimed and that warrants therefore have been issued, or funds made available for the payments in kind listed herein according to law and the rules and regulations of the Department of Social Services.	
SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE
48 800B (10-82)			

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of AD 800B

INSTRUCTIONS FOR USE OF FORM AD 800B

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with amounts shown on the integrated payroll summary. (For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.) Line 4 has been omitted from the form because there are no provisions to reduce grants to zero due to prior overpayments.
3. Enter the subtotals in Lines 6 and 10, and totals in Lines 12A and B.
4. Line 13B - Enter line 12B.
5. Line 13C - Enter line 12B.
6. Lines 14 and 15 - Reserved for the application of adjustments made by the state (State Field Audit Exceptions, etc.).
7. Lines 16 and 17 - Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

AD 800B (Back) Instructions (10-82)

25-605 FORMS (Continued)

26-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800

STATE OF CALIFORNIA - DEPARTMENT OF SOCIAL SERVICES

**SUMMARY REPORT
OF ASSISTANCE EXPENDITURES
AID TO FAMILIES WITH DEPENDENT CHILDREN**

FAMILY GROUP FID STATE USE DSS COUNTY WELFARE COUNTY AID FOR
 UNEMPLOYED AU STATE COUNTY

INSTRUCTIONS OR REVERSE SIDE OF FORM

FEDERAL PERSONS COUNT		NON-FEDERAL PERSONS COUNT		COUNTY	STATE	TOTAL
ADULTS	CHILDREN	ADULTS	CHILDREN			
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9
10	10	10	10	10	10	10
11	11	11	11	11	11	11
12	12	12	12	12	12	12
13 Total Federal Persons Col. A plus C1				13	13C minus 15A + 15A + 3	
14 Total Persons Col. A plus C1 plus C2 plus C3				14	14A minus 15A minus 5 E	
15 Federal Ratio (13A ÷ 14A carry to 4 places)				15	15A + 51.00	
16 Number of Assistance Units represented by 14A (total persons)				16	16A + 52.00	
17 Federal AU's (15A ÷ 15A rounded to nearest whole number)				17	17C + 17C	
18 Nonfederal AU's (14A minus 17A)						
19 Immediate need payments not subject to state participation						
				D	E	F
				18A minus 18B	18C minus 18D plus 18E minus 18F plus 18G	18H minus 18I minus 18J minus 18K
20						
21	REPAYMENTS		1	1	1	1
22	GRAND TOTALS		\$	\$	\$	\$
				(18A minus 18B) plus 21C	(18C minus 18D) plus 21D	(18E minus 18F) plus 21E
23 (FOR STATE USE)						
24						
25 (FOR COUNTY USE)						
				A		

I hereby certify under penalty of perjury that I am the official responsible for the administration of Aid to Families with Dependent Children in and for aforesaid county that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code, that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

I hereby certify under penalty of perjury that I am the officer in aforesaid county responsible for the examination and settlement of accounts, that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code, that the amounts claimed herein are in accordance with authorizations for Aid to Families with Dependent Children made by the county, that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR DATE SIGNATURE OF COUNTY SUPERVISOR DATE

CA 800 (1-80)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800

INSTRUCTIONS FOR USE OF FORM CA 800 (FG AND U)

1. Enter county name and month and year of claim in space provided.
2. Complete Lines 1 through 5, and 7 through 9, in accordance with the amounts shown on the integrated payroll summary. (For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.) All money amounts on this form may be rounded to the nearest dollar.
3. Enter the subtotals in Lines 6 and 10 and the total in Line 12.
4. Line 13A — Add Column A (total federal persons).
5. Line 14A — Add Column A (total federal persons) and Column B (total nonfederal persons).
6. Line 15A — Divide 13A (total federal persons) by 14A (total persons) to determine federal ratio.
7. Line 19A — Determine amount of immediate need not subject to state participation.

Federal and nonfederal AUs are computed as follows:

8. Line 16A — Enter the total Assistance Units (cases) from the CA 237 report.
9. Line 17A — Multiply 16A (total number of AUs) by 15A (federal ratio) to determine federal AUs.
10. Line 18A — Subtract 17A (total federal AUs) from 16A (total number of AUs) to determine nonfederal AUs.

Federal share is computed as follows:

11. Line 13D — Subtract 19A (immediate need payments not subject to state participation) from 12C (net total aid paid), then multiply by 15A (federal ratio) and by .5 to determine 50 percent federal share of total aid paid.
12. Line 14D — Multiply 19A (immediate need payments not subject to state participation) by 15A (federal ratio) and by .5 to determine 50 percent federal share of these payments.

State share is computed as follows:

13. Line 15E — Multiply 17A (total federal AUs) by \$1.00 (the state share of the \$2.00 grant increase effective 6-1-73 for federal AUs).
14. Line 16E — Multiply 18A (total nonfederal AUs) by \$2.00 (the state share of the \$2.00 grant increase effective 6-1-73 for nonfederal AUs).
15. Line 17E — Add 15E (state share of grant increase for federal AUs) and 16E (state share of grant increase for nonfederal AUs) to determine the total state share of the 6-1-73 increase.

Compute total federal, state, and county shares as follows:

16. Line 20D — Add Lines 13D (federal share of net total aid paid) and 14D (federal share of immediate need payments not subject to state participation) to determine total federal share.
17. Line 20E — Subtract Lines 19A (immediate need payments not subject to state participation), 13D (federal share of net total aid paid), and 17E (total state share of 6-1-73 increase from Line 12C (net total aid paid), then multiply by 89.2 percent (state share of participation) to determine basic state share. (Total state share is shown in Line 22E.)
18. Line 20F — Subtract Lines 17E (total state share of 6-1-73 increase), 20D (total federal share), and 20E (basic state share) from Line 12C (total aid paid) to determine total county share.
19. Line 21C — Enter total repayments from Repayment Contra Rolls.
20. Line 21D, E, and F — Enter the federal, state, and county shares of repayments determined in accordance with ratio shown in MPP Section 25-5702.
21. Line 22C, D, E, and F — Enter grand totals.
22. Line 23 and 24 — Reserved for the application of adjustments made by the state (Federal and/or State Field Audit Exceptions, etc.)
23. Lines 25C and F and 26B, C, D, E, F — Included at county request and use is optional. If adjustments are reported in Line B which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

CA 800 (1-85) Back

**FISCAL MANAGEMENT AND CONTROL
FORMS**

Handbook

25-605 (Cont.)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800 FC (FED)

A. PERSONS COUNT		B. AMOUNTS	SOURCE DOCUMENTS		
			1.	Main Payroll	
			2.	Current Month Supplemental Payroll	
{ }	{ }		3.	Current Month Cancellation Contra Roll	
			5.	Prior Months Supplemental Payroll	
			6.	Subtotal (reconciliation totals)	
{ }	{ }		7.	Prior Months Cancellation Contra Roll	
{ }	{ }		8.	Abatements	
			9.	Schedule of Adjustments (show minus items in parentheses)	
			10.	Subtotals (Lines 7, 8, 9)	
			11.	DSS Office Audit Corrections (for STATE use only)	
			12.	TOTAL	
			13.	Amount not Reimbursable from Federal Funds	
			14.	Amount not Reimbursable from State Funds	
			15.	Line 14A x 5	
			16.	REPAYMENTS	
			17.	GRAND TOTALS	
			18.		
			19.		
			20.	FUNERAL COSTS (11-405.2)	
			21.	(FOR COUNTY USE)	
			22.		

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Aid to Families with Dependent Children in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.		I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Aid to Families with Dependent Children made by the county; that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.	
SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

CA 800 FC (FED) 10 (8)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800 FC (FED)

INSTRUCTIONS FOR USE OF FORM CA 800 FC (FEDERAL)

1. Enter county name and month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary (for nonintegrated payrolls enter grand totals shown for each payroll or contra roll). All money amounts on the Form CA 800 FC (Federal) may be rounded to the nearer dollar. **Note:** Line 4 (Zero Grant Persons Count) has been deleted because under the AFDC-FC Program there is no provision for reducing a grant to zero to recover a previous overpayment.
3. Enter the subtotals in Lines 6 and 10 and the totals in Line 12.
4. Line 13A - Enter the net amount not reimbursable from federal funds.
(Example: Social worker services, interest on original acquisition mortgages and costs incurred for leasebacks in accordance with the AFDC-Foster Care Group Home Rate Limiting).
5. Line 14A - Enter the amount not reimbursable from state funds.
(Example: Total payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling.)
6. Line 15A - Enter the total nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (Line 14A x 5).
7. Line 15C - Enter the federal share: total aid paid (12B) minus the amount not reimbursable from federal funds (13A) multiplied by 50 percent.
8. Line 15D - Enter the state share: total aid paid (12B) minus the total nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (15A) minus federal share (15C) multiplied by 95 percent.
9. Line 15E - Enter the county share: total aid paid (12B) minus federal share (15C) minus state share (15D).
10. Line 16 - Enter the total repayments as reported on the Repayment Contra Roll.
11. Line 17 - Enter grand totals.
12. Lines 18 and 19 - Reserved for state use.
13. Line 20 - To be used for claiming of reimbursement for funeral costs for foster care children in accordance with MPP Handbook Section 11-405.2 (see also MPP Handbook Section 25-753).
14. Lines 21 and 22 - Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800 FC.1 (FED)

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY

INSTRUCTIONS ON REVERSE SIDE OF FORM

FORM 25-605 (REV. 7/86)

FOSTER CARE FACILITY EXPENDITURE STATEMENT

AMOUNTS NOT REIMBURSABLE FROM FEDERAL FUNDS

Page _____ of _____

Check use AFDC FC EA FC

A FACILITY NAME	B PROGRAM NUMBER	C - ORIGINALLY CLAIMED			D - REVISED			E - ADJUSTED		
		1 PERSONS AND PAID CLAIM	2 TOTAL FEDERAL WORKER MONTHLY OTHER AMOUNT (\$)	3 SOCIAL SECURITY OTHER MONTHLY AMOUNT (\$)	1 PERSONS AND PAID CLAIM	2 TOTAL FEDERAL WORKER MONTHLY OTHER AMOUNT (\$)	3 SOCIAL SECURITY OTHER MONTHLY AMOUNT (\$)	1 PERSONS AND PAID CLAIM	2 TOTAL FEDERAL WORKER MONTHLY OTHER AMOUNT (\$)	3 SOCIAL SECURITY OTHER MONTHLY AMOUNT (\$)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800 FC.1 (FED)

INSTRUCTIONS FOR USE OF FORM CA 800 FC. 1 (Fed)

1. Enter county name, facility name, program number, page number, month and year in the spaces provided and check the program designation block.
2. Lines C1, D1, E1 - Enter persons owed for payments coded E (E is to be used for payments that include Medicaid other amounts and or social worker services) in accordance with the AEDC FC Group Home Rate Listing.)
3. Line C2, D2, E2 - Enter the amount paid (Do not enter any amounts in these columns for payments whose state set rate, Social worker services, and Medicaid other percentages should be applied to the state set rate.)
4. Lines C3, D3, E3 - Enter the social worker services percentage from the AEDC FC Group Home Rate Listing.
5. Lines C4, D4, E4 - Enter the Medicaid other percentage from the AEDC FC Group Home Rate Listing.
6. Lines C5, D5, E5 - Enter the total social worker services. Medicaid other amounts. Column 2 multiplied by the total of columns 3 and 4.
7. Enter the subtotals for columns 2 and columns 5 on each page.
8. Enter the grand total for columns 2 and columns 5 on the last page.

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800 FC.2 (FED)

**FOSTER CARE FACILITY EXPENDITURE STATEMENT
AMOUNTS NOT REIMBURSABLE FROM STATE FUNDS**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
COUNTY _____

REPAYMENT OF OTHER SERVICES
Page _____ of _____
Check one
AFC-FC EA-FC

A. FACILITY NAME/CASE NAME	B. PROGRAM NUMBER/CASE NUMBER	C. ORIGINALLY CLAIMED		D. REVISED		E. ADJUSTED	
		(1) PRISON COUNT	(2) TOTAL AND PAID	(1) PRISON COUNT	(2) TOTAL AND PAID	(1) PRISON COUNT	(2) TOTAL AND PAID
			(3) TOTAL AMOUNT NOT REIMBURSABLE FROM STATE FUNDS		(3) TOTAL AMOUNT NOT REIMBURSABLE FROM STATE FUNDS		(3) TOTAL AMOUNT NOT REIMBURSABLE FROM STATE FUNDS

CALSB01CZ (FEB 19 86)

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800A FC (NONFED)

STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES	
SUMMARY REPORT OF ASSISTANCE EXPENDITURES -		For State Use <input type="checkbox"/> DSS <input type="checkbox"/> County Welfare <input type="checkbox"/> County Auditor	
NONFEDERAL CHILDREN IN FOSTER CARE		COUNTY	DATE (MONTH YEAR)
(Instructions on reverse side of form)			
A	B	SOURCE DOCUMENTS	
PERSONS COUNT	AMOUNTS		
		1. Main Payroll	
		2. Current Month Supplemental Payroll	
{ }	{ }	3. Current Month Cancellation Contra Roll	
		5. Prior Months Supplemental Payroll	
		6. Subtotal (reconciliation totals)	
{ }	{ }	7. Prior Months Cancellation Contra Roll	
{ }	{ }	8. Abatements	
		9. Schedule of Adjustments (show minus items in parentheses)	
		10. Subtotals (Lines 7, 8, 9)	
		11. DSS Office Audit Corrections (for state use only)	
		12. TOTAL	
		C	D
		STATE	COUNTY
		(Line 12B x .95)	(Line 12B minus Line 13C)
			13.
REPAYMENTS	{ }	{ }	{ }
			14.
GRAND TOTALS	(Lines 12B and 14B)	(Lines 13C and 14C)	(Lines 13D and 14D)
			15.
			16.
FUNERAL COSTS (11-405.2)			17.
			18.
FOR COUNTY USE			19.
			20.
I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Aid to Families with Dependent Children in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.		I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Aid to Families with Dependent Children made by the county; that said amounts correctly reflect State and County Shares in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.	
SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE
CA 800A FC (NONFED) (12-86)			

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800A FC (NONFED)

INSTRUCTIONS FOR USE OF FORM CA 800A FC (NONFEDERAL)

1. Enter county name and month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary (for nonintegrated payrolls enter grand totals shown for each payroll or contra roll). All money amounts on the Form CA 800A FC (Non-Federal) may be rounded to the nearer dollar. **Note:** Line 4 (Zero Grant Persons Count) has been deleted because under the AFDC-FC Program there is no provision for reducing a grant to zero to recover a previous overpayment.
3. Enter the subtotals in Lines 6 and 10 and the totals in Line 12.
4. Line 13C - Enter the state share: total aid paid (12B) multiplied by 95 percent.
5. Line 13D - Enter the county share: total aid paid (12B) minus state share (13C).
6. Line 14 - Enter the total repayments as reported on the Repayment Contra Roll.
7. Line 15 - Enter grand totals.
8. Lines 16 and 17 - Reserved for State Use.
9. Line 18 - To be used for claiming of reimbursement for funeral costs for foster care children in accordance with EAS Manual Section 11-405.2 (see also Fiscal Handbook Section 25-753).
10. Lines 19 and 20 - Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 843

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES
FEDERAL FUNDS CLAIMABLE BASED ON THE EXPENDITURES FOR REFUGEE RESETTLEMENT, CUBAN PROGRAM PHASEDOWN AND CUBAN/HAITIAN ENTRANT RECIPIENTS IN RECEIPT OF NONFEDERAL AFDC-FC		
COUNTY	DATE (MONTH/YEAR)	
REFUGEE RESETTLEMENT PROGRAM RECIPIENTS	EXPENDITURES	PERSONS COUNT
(Subsequent to 3/31/81, expenditures for time-eligible refugees only are claimable).		
1. Refugee Resettlement recipients in receipt of nonfederal AFDC-FC (Do not include unaccompanied refugee minors).	\$ _____	[]
2. Federal funds claimable for Refugee Resettlement Program recipients (Line 1 x 100%).	\$ []	
CUBAN PROGRAM PHASEDOWN RECIPIENTS	EXPENDITURES	PERSONS COUNT
3. Cuban Program Phasedown recipients in receipt of nonfederal AFDC-FC.	\$ _____	[]
4. Federal funds claimable for Cuban Program Phasedown recipients (Line 3 x _____%).*	\$ []	
CUBAN / HAITIAN ENTRANTS	EXPENDITURES	PERSONS COUNT
5. Cuban/Haitian Entrants in receipt of nonfederal AFDC-FC. (Do not include unaccompanied entrant minors).	\$ _____	[]
6. Federal funds claimable for Cuban/Haitian Entrants (Line 5 x 100%).	\$ []	
7. State share of additional federal funds claimable:		
a. Total nonreimbursable rate increase paid:		
(1) In behalf of Refugee Resettlement recipients (Amount x 100%).	\$ _____	
(2) In behalf of Cuban Program Phasedown recipients (Amount x _____%).*	\$ _____	
(3) In behalf of Cuban/Haitian Entrants (Amount x 100%).	\$ _____	
b. Total state share of claimable amount: (Line 2 minus a(1) above) plus (Line 4 minus a(2) above) plus (Line 6 minus a(3) above) x 95%.	\$ []	
B. County share of additional federal funds claimable: (Line 2 plus Line 4 plus Line 6 minus Line 7b).	\$ []	
* Complete in accordance with instructions from DSS.		
CERTIFICATION		
This is to certify that the above information is correct to the best of my knowledge and belief, and that payment for these expenditures has not been received. Records and amounts in support of this claim are available for review and audit.		
SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE
OFFICE USE ONLY		

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 843

INSTRUCTIONS FOR USE OF FORM DFA 843

Enter the county name and the month and year of the claims in the space provided.

Complete the following 2 items in accordance with data for Refugee Resettlement recipients of nonfederal AFDC-FC as summarized at the end of the nonfederal AFDC-FC payroll:

1. Enter total expenditures and persons count in Line 1.
2. Compute the federal funds claimable by multiplying Line 1 by 100%. Enter the amount in Line 2.

Complete the following 2 items in accordance with data for Cuban Program Phasedown recipients of nonfederal AFDC-FC as summarized at the end of the nonfederal AFDC-FC payroll:

3. Enter total expenditures and persons count in Line 3.
4. Compute the federal funds claimable by multiplying Line 3 by the applicable percentage. Enter the amount in Line 4.

Complete the following 2 items in accordance with data for Cuban/Haitian Entrant recipients of nonfederal AFDC-FC as summarized at the end of the nonfederal AFDC-FC payroll:

5. Enter total expenditures and persons count in Line 5.
6. Compute the federal funds claimable by multiplying Line 5 by 100%. Enter the amount in Line 6.

Determine the state share of additional federal funds claimable as follows:

Determine the nonreimbursable rate increases paid for recipients included in this report. If an amount was paid in behalf of:

7. a(1) Refugee Resettlement recipients, multiply the amount by 100% and enter in Line 7a(1).
a(2) Cuban Program Phasedown recipients, multiply the amount by the applicable percentage and enter in Line 7a(2).
a(3) Cuban/Haitian Entrants, multiply the amount by 100% and enter in Line 7a(3).
 - b. Compute the state share of the additional federal funds claimable by multiplying the total of: Line 2 minus Line a(1); Line 4 minus Line a(2) and Line 6 minus Line a(3) by 95%. Enter the amount in Line 7b.
8. Enter the county share of the additional federal funds claimable in Line 8. (Add Lines 2, 4 and 6 and subtract Line 7b).

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 844 RDP

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES							
ADDITIONAL FEDERAL FUNDS CLAIMABLE BASED ON THE NONFEDERAL SHARE OF EXPENDITURES FOR REFUGEE DEMONSTRATION PROJECT RECIPIENTS (RDP)									
		<input type="checkbox"/> FAMILY GROUP <input type="checkbox"/> UNEMPLOYED							
<i>NOTE: Complete in accordance with instructions from DSS.</i>									
COUNTY		DATE (MONTH/YEAR)							
	REFUGEE DEMONSTRATION PROJECT RECIPIENTS	EXPENDITURES	PERSONS COUNT						
-		A.							
1. Total for those cases which include one or more time eligible Refugee Demonstration Project Recipients.	\$ _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">B. FEDERAL</td> <td style="width: 33%;">C. NONFEDERAL</td> <td style="width: 33%;">D. TOTAL</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>		B. FEDERAL	C. NONFEDERAL	D. TOTAL			
B. FEDERAL	C. NONFEDERAL	D. TOTAL							
2. Federal Percentage (1B ÷ 1D) _____ %									
3. Expenditures reported in Item 1 which were made in behalf of federally eligible persons. (Item 2 × 1A)	\$ _____								
4. Nonfederal share of amount in Item 3. (3A × .5)	\$ _____								
5. Expenditures reported in Item 1 which were made in behalf of nonfederal persons. (1A minus 3A)	\$ _____								
6. Total nonfederal share of RDP expenditures in Item 1. (4A + 5A)	\$ _____								
7. Time eligible percentage (7C ÷ 7B) _____ %		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">B. TOTAL CLAIM AS TO ABOVE</td> <td style="width: 50%;">C. TIME ELIGIBLE REFUGEE COUNT</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> </table>		B. TOTAL CLAIM AS TO ABOVE	C. TIME ELIGIBLE REFUGEE COUNT				
B. TOTAL CLAIM AS TO ABOVE	C. TIME ELIGIBLE REFUGEE COUNT								
8. Additional federal funds claimable for time eligible Refugee Demonstration Project recipients. (Item 7 × 6A)	\$ _____								
9. Total state share of additional federal funds claimable (Line 8) × 89.2%.	\$ _____								
10. County share of additional federal funds claimable. (Line 9 minus Line 8)	\$ _____								
CERTIFICATION									
<i>This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and accounts in support of this claim are available for review and audit.</i>									
SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE							
DFA 844 RDP (2, 86)									

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 844 RDP

INSTRUCTIONS FOR USE OF FORM DFA 844 RDP

Complete the following 10 items in accordance with data for all cases (AUs) which include one or more time eligible Refugee Demonstration Project recipients.

1. In Line 1A enter total expenditures; in 1B enter the federal persons count, in 1C enter the nonfederal persons count; and in 1D enter the total persons count.
2. Determine the federal percentage by dividing federal persons count by the total persons count. Enter the percentage in Line 2.
3. Multiply total expenditures reported in 1A by the federal percentage (Item 2) to determine the amount expended in behalf of federally eligible persons. Enter the amount in Line 3.
4. In Line 4 enter the nonfederal share of expenditures shown in Line 3 (Line 3 multiplied by 50%).
5. In Line 5 enter that portion of the expenditures in 1A made in behalf of nonfederal persons: Subtract 3A (portion expended in behalf of federal persons) from 1A (total expended).
6. Determine the total nonfederal share by adding 4A and 5A. Enter the amount in Line 6.
7. In 7B enter the total persons count shown in Line 1, Column D. In 7C enter the time eligible persons count. Determine the time eligible percentage by dividing the time eligible person count by total persons count. Enter the percentage in the space provided in Line 7.
8. Enter the additional federal funds claimable for time eligible Refugee Demonstration Project recipients in Line 8: Multiply the nonfederal share of RDP expenditures (Item 6) by the percentage shown in Item 7.
9. Compute the state share of additional federal funds claimable by multiplying the total of: Line 8 by 89.2 percent. Enter the amount in Line 9.
10. Enter the county share of the additional federal funds claimable in Line 10. (Line 8 minus Line 9).

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 847

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES
ADDITIONAL FEDERAL FUNDS CLAIMABLE BASED ON THE NONFEDERAL SHARE OF EXPENDITURES FOR REFUGEE RESETTLEMENT, CUBAN PROGRAM PHASEDOWN AND CUBAN/ HAITIAN ENTRANT RECIPIENTS IN RECEIPT OF FEDERAL AFDC-FC		
COUNTY	DATE (MONTH/YEAR)	
REFUGEE RESETTLEMENT PROGRAM RECIPIENTS	EXPENDITURES	PERSONS COUNT
(Subsequent to 3/31/81, expenditures for time-eligible refugees only are claimable).		
1. Refugee Resettlement Recipients in receipt of federal AFDC-FC (Do not include Cuban Program Phasedown recipients).	\$ _____	[]
2. Nonfederal share of amount shown in item 1 (Line 1 x .5).	\$ _____	
3. Additional federal funds claimable for Refugee Resettlement Program recipients (Line 2 x 100%).	\$ []	
CUBAN PROGRAM PHASEDOWN RECIPIENTS	EXPENDITURES	PERSONS COUNT
4. Cuban Program Phasedown recipients in receipt of federal AFDC-FC.	\$ _____	[]
5. Nonfederal share of amount shown in item 4 (Line 4 x .5).	\$ _____	
6. Additional federal funds claimable for Cuban Program Phasedown recipients (Line 5 x _____%). *	\$ []	
CUBAN / HAITIAN ENTRANTS	EXPENDITURES	PERSONS COUNT
7. Cuban/Haitian Entrants in receipt of federal AFDC-FC.	\$ _____	[]
8. Nonfederal share of amount shown in item 7 (Line 7 x .5).	\$ _____	
9. Additional federal funds claimable for Cuban/Haitian Entrants (Line 8 x 100%).	\$ []	
10. State share of additional federal funds claimable:		
a. Total nonfederal share of nonreimbursable rate increase paid:		
(1) In behalf of Refugee Resettlement recipients (Amount x 100%).	\$ _____	
(2) In behalf of Cuban Program Phasedown recipients (Amount x _____%). *	\$ _____	
(3) In behalf of Cuban/Haitian Entrants (Amount x 100%).	\$ _____	
b. Total state share of claimable amount: (Line 3 minus a(1) above) plus (Line 6 minus a(2) above) plus (Line 9 minus a(3) above) x 95%.	\$ []	
11. County share of additional federal funds claimable: (Line 3 plus Line 6 plus Line 9 minus Line 10b).	\$ []	
* Complete in accordance with instructions from DSS.		
CERTIFICATION		
This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and amounts in support of this claim are available for review and audit.		
SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE
DFA 847 (1/81)		

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 847

INSTRUCTIONS FOR USE OF FORM DFA 847

Enter the county name and the month and year of the claim in the space provided.

Complete the following 3 items in accordance with data for Refugee Resettlement recipients of federal AFDC-FC as summarized at the end of the AFDC-FC payroll:

1. Enter total expenditures and persons count in Line 1.
2. In Line 2, enter the nonfederal share of the expenditures shown in Line 1 (Line 1 multiplied by 50%).
3. Determine the additional federal funds claimable by multiplying Line 2 by 100%. Enter the amount in Line 3.

Complete the following 3 items in accordance with data for Cuban Program Phasedown recipients of federal AFDC-FC as summarized at the end of the AFDC-FC payroll:

4. Enter total expenditures and persons count in Line 4.
5. In Line 5, enter the nonfederal share of the expenditures shown in Line 4 (Line 4 multiplied by 50%).
6. Determine the additional federal funds claimable by multiplying Line 5 by the applicable percentage. Enter the amount in Line 6.

Complete the following 3 items in accordance with data for Cuban/Haitian Entrant recipients of federal AFDC-FC as summarized at the end of the AFDC-FC payroll:

7. Enter total expenditures and persons count in Line 7.
8. In Line 8, enter the nonfederal share of the expenditures shown in Line 7 (Line 7 multiplied by 50%).
9. Determine the additional federal funds claimable by multiplying Line 8 by 100%. Enter the amount in Line 9.

Determine the state share of additional federal funds claimable as follows:

Determine the nonfederal share of nonreimbursable rate increases paid for recipients included in this report. If an amount was paid in behalf of:

10. a(1) Refugee Resettlement recipients, multiply the amount by 100% and enter in Line 10a(1).
a(2) Cuban Program Phasedown recipients, multiply the amount by the applicable percentage and enter in Line 10a(2).
a(3) Cuban/Haitian Entrants, multiply the amount by 100% and enter in Line 10a(3).
- b. Determine the state share of the additional federal funds claimable by multiplying the total of: Line 3 minus Line a(1); Line 6 minus Line a(2) and Line 9 minus Line a(3) by 95%. Enter the amount in Line 10b.
11. Enter the county share of the additional federal funds claimable in Line 11. (Add Lines 3, 6 and 9 and subtract Line 10b).

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 859

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY FEDERAL FUNDS CLAIMABLE BASED ON EXPENDITURES FOR TIME ELIGIBLE REFUGEES AND ENTRANTS IN RECEIPT OF GENERAL ASSISTANCE		DEPARTMENT OF SOCIAL SERVICES <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th align="center" colspan="2">FOR STATE USE</th> </tr> <tr> <td><input type="checkbox"/></td> <td>SDSS</td> </tr> <tr> <td><input type="checkbox"/></td> <td>County Welfare</td> </tr> <tr> <td><input type="checkbox"/></td> <td>County Auditor</td> </tr> </table>	FOR STATE USE		<input type="checkbox"/>	SDSS	<input type="checkbox"/>	County Welfare	<input type="checkbox"/>	County Auditor	
FOR STATE USE											
<input type="checkbox"/>	SDSS										
<input type="checkbox"/>	County Welfare										
<input type="checkbox"/>	County Auditor										
COUNTY _____		DATE (MONTH) _____ (YEAR) _____									
A PERSONS COUNT	B TOTAL AID PAID	SOURCE DOCUMENTS									
		1. Main Payroll									
		2. Current month supplemental payroll									
		3. Current month cancellation contra roll									
		5. Prior months supplemental payroll									
		6. SUBTOTAL (reconciliation totals)									
		7. Prior months cancellation contra roll									
		8. Abatements and repayments									
		9. Schedule of adjustments (show minus items in parentheses)									
		10. SUBTOTAL (Lines 7, 8, 9)									
		11. SDSS office audit corrections (for state use)									
		12. TOTALS									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th align="center" colspan="3">C FEDERAL SHARE</th> </tr> <tr> <td style="width: 20%;">GRAND TOTALS</td> <td> </td> <td> </td> </tr> <tr> <td>Refugees and Entrants</td> <td align="center">Enter Line 12B</td> <td align="center">Line 13B x 100%</td> </tr> </table>		C FEDERAL SHARE			GRAND TOTALS			Refugees and Entrants	Enter Line 12B	Line 13B x 100%	13.
C FEDERAL SHARE											
GRAND TOTALS											
Refugees and Entrants	Enter Line 12B	Line 13B x 100%									
CERTIFICATION											
<i>I hereby certify, under penalty of perjury, that I am the official responsible for the Administration of General Assistance in and for the aforesaid county; that the above information is correct to the best of my knowledge and belief; that payment for these expenditures has not been received; and that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code.</i>											
SIGNATURE OF AGENCY OFFICIAL _____	TITLE _____	DATE _____									
		19									
DFA 859 (4/86)											

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 859

INSTRUCTIONS FOR USE OF FORM DFA 859

1. This form can be used for claiming federal reimbursement of General Assistance expenditures for time eligible refugees and entrants.
2. Enter county name and the month and year of the claim in the space provided.
3. Complete Lines 1 through 5, and 7 through 9 in accordance with the amounts shown on the integrated payroll summary. *(On nonintegrated payrolls, enter grand totals shown for each payroll or contra. roll.)*
4. Enter the subtotals on Lines 6 and 10 and totals on Line 12.
5. The federal share is computed as follows:
 - a. For time eligible refugees and entrants — (Line 13) Line 13c: Multiply Line 13b (total aid paid) by 100% (federal reimbursement for time eligible refugees and entrants aided on the General Assistance Program).

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 863

STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
184 P STREET, S.F. 8-300
SACRAMENTO, CA 95814

ADDITIONAL FEDERAL FUNDS CLAIMABLE BASED ON THE NONFEDERAL SHARE OF EXPENDITURES FOR REFUGEE RESETTLEMENT AND CUBAN/HAITIAN ENTRANT RECIPIENTS IN RECEIPT OF EMERGENCY ASSISTANCE -- UNEMPLOYED PARENT

COUNTY _____
DATE (MONTH-YEAR) _____

REFUGEE RESETTLEMENT PROGRAM RECIPIENTS <i>(Subsequent to 4/3/31/81, expenditures for time-eligible refugees only are claimable.)</i>	EXPENDITURES		PERSONS COUNT	
	A.	B.	B.	C.
1. Totals for those EA-UP cases which include one or more time eligible Refugee Resettlement Recipients	\$ _____	TOTAL		
2. Nonfederal share of amount in Item 1A (1A x .5)	\$ _____	TOTAL		TOTAL TIME-ELIGIBLE RECIPIENTS (COUNT)
3. Time-eligible percentage (3C ÷ 3B) _____ %				
4. Additional federal funds claimable for time eligible Refugee Resettlement Program recipients (Line 3 percentage x 2A)	\$ _____			

CUBAN/HAITIAN ENTRANTS	EXPENDITURES		PERSONS COUNT	
	A.	B.	B.	C.
5. Totals for those EA-UP cases which include one or more time-eligible Cuban/Haitian Entrants	\$ _____	TOTAL		
6. Nonfederal share of amount in Item 5A (5A x .5)	\$ _____	TOTAL		TOTAL TIME-ELIGIBLE RECIPIENTS (COUNT)
7. Time-eligible percentage (7C ÷ 7B) _____ %				
8. Additional federal funds claimable for time eligible Cuban/Haitian Entrants (Line 7 percentage x 5A)	\$ _____			

9. State share of additional federal funds claimable:

a. County supplement paid in behalf of Refugee Resettlement Programs Recipients (Amount x 100%)

b. County supplement paid in behalf of Cuban/Haitian Entrants (Amount x 100%)

c. Total state share of additional federal funds claimable (Line 4A minus Line 9a) plus (Line 8A minus Line 9b) x 89.2%

10. County share of additional federal funds claimable (Line 4A plus Line 8A minus Line 9c)

CERTIFICATION

This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and accounts in support of this claim are available for review and audit.

SIGNATURE OF AGENCY OFFICIAL _____ TITLE _____ DATE _____

DFA 863 (12-82)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 863

INSTRUCTIONS FOR USE OF FORM DFA 863

Enter the county name and the month and year of the claim in the space provided.

Complete the following 5 items in accordance with data for all Emergency Assistance - UP cases which include one or more time-eligible Refugee Resettlement Recipients as summarized at the end of the EA--UP payroll.

1. Line 1A - Enter total expenditures.
2. Line 1B - Enter the total persons count.
3. Line 2A - Enter the nonfederal share of expenditures; multiply Line 1A x 50 percent.
4. Line 3 - Enter the total persons counts in Line 3B; enter the time-eligible persons counts in Line 3C. Determine the time-eligible percentage by dividing the time-eligible persons count by total persons count. Enter the percentage in the space provided in Line 3.
5. Line 4A - Enter the additional federal funds claimable for time-eligible Refugee Resettlement Program Recipients in Line 4A; Multiply the nonfederal share of EA expenditures (Line 2A) by the percentage shown in Line 3.

Complete the following 5 items in accordance with data for all Emergency Assistance - UP cases which include one or more time-eligible Cuban/Haitian recipients as summarized at the end of the EA--UP payroll.

6. Line 5A - Enter total expenditures.
7. Line 5B - Enter total persons count.
8. Line 6A - Enter the nonfederal share of expenditures; multiply Line 5A x 50 percent.
9. Line 7 - Enter the total persons counts in Line 7B; enter the time-eligible persons counts in Line 7C. Determine the time-eligible percentage by dividing the time-eligible persons count by total persons count. Enter the percentage in the space provided in Line 7.
10. Line 8A - Enter the additional federal funds claimable for time-eligible Cuban/Haitian Entrants recipients in Line 8A; Multiply the nonfederal share of EA expenditures (Line 5A) by the percentage shown in Line 7.
11. Line 9a - If county supplement was paid in behalf of Refugee Resettlement recipients, multiply the amount by 100% and enter in Line 9a.
12. Line 9b - If county supplement was paid in behalf of Cuban/Haitian Entrants, multiply the amount by 100% and enter in Line 9b.
13. Line 9C - Compute the state share of additional funds claimable: (Line 4A minus Line 9a) plus (Line 8A minus Line 9b) multiplied by 89.2 percent.
14. Line 10 - Enter the county share of additional federal funds claimable: Line 4A plus Line 8A minus Line 9c.

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- SC 800

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES	
SUMMARY REPORT OF SPECIAL CIRCUMSTANCES			
For State Use → <input type="checkbox"/> DSS <input type="checkbox"/> County Welfare <input type="checkbox"/> County Auditor			
COUNTY	DATE (MONTH, YEAR)	FISCAL YEAR	
AGED (A)	BLIND (B)	DISABLED (C)	SOURCE DOCUMENTS
			1. Main Payroll
			2. Current month supplemental payroll
()	()	()	3. Current month cancellation contra roll
			5. Prior months supplemental payroll
			6. SUBTOTAL (reconciliation totals)
()	()	()	7. Prior months cancellation contra roll
()	()	()	8. Abatements
			9. Schedule of adjustments (show minus items in parentheses)
			10. SUBTOTAL (Lines 7, 8, 9)
			11. DSSW office audit corrections (For state use only)
			12. TOTAL
GRAND TOTALS (Item 12, Columns A, B and C)			\$
(FOR STATE USE)			
I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Special Circumstances in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.		I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorization for Special Circumstances made by the county; that said amounts correctly reflect State share in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.	
SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE
SC 800 (12/76)			

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- SOC 800

STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, M.S. 8-300

SUMMARY REPORT OF ASSISTANCE EXPENDITURES
EMERGENCY ASSISTANCE - FOSTER CARE

STATE USE ONLY
 DSS County Welfare
 County Auditor
 DATE (MONTH YEAR)

COUNTY: _____

(Instructions on Reverse side of Form.)

A PERSONS COUNT	B AMOUNTS	
		1. Main Payroll.
		2. Current Month Supplemental Payroll.
()	()	3. Current Month Cancellation Contra Roll.
		5. Prior Months Supplemental Payroll.
		6. Subtotal (Reconciliation Totals).
()	()	7. Prior Months Cancellation Contra Roll.
()	()	8. Abatements.
		9. Schedule of Adjustments (Show Minus Items in Parentheses.)
		10. Subtotals (Lines 7, 8, 9).
		11. DSS Office Audit Corrections (For State Use Only).
		12. Total.
		13. Amounts not Reimbursable from Federal Funds
		14. Amount not Reimbursable from State Funds
		15. Line 14A x 5
		16. Repayments
		17. Grand Totals
		18. FOR STATE USE
		19. FOR COUNTY USE
		20.
		21.

D FEDERAL **E STATE** **F COUNTY**
(LINE 12B MINUS LINE 12A) x 5 (LINE 12B MINUS LINE 12A MINUS LINE 15D) x 95 (LINE 12B MINUS LINE 15D MINUS LINE 18E)

17 Grand Totals (Line 12B and Line 15C) (Line 15D and Line 18D) (Line 15E and Line 18E) (Line 15F and Line 18F)

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Emergency Assistance in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, and repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Emergency Assistance made by the county; that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefor have been issued according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR DATE SIGNATURE OF COUNTY AUDITOR OR CONTROLLER DATE

SEC 800-119 85+

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of SOC 800

INSTRUCTIONS FOR USE OF FORM SOC 800

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary. (For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.) All money amounts on this form may be rounded to the nearest dollar.
3. Enter the subtotals in Lines 6 and 10 and the total in Line 12.
4. Line 13A - Enter the net amount not reimbursable from federal funds (Example: Non Federal Other Amounts in accordance with The AFDC-Foster Care Group Home Rate Listing.)
5. Line 14A - Enter the amount not reimbursable from state funds (Example: Total payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling.)
6. Line 15A - Enter the total nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (Line 14A x .5).
7. Line 15D - Enter the federal share in Line 15D: total aid paid (Line 12B) minus amounts not reimbursable from federal funds (Line 13A) multiplied by 50 percent.
8. Line 15E - Enter the state share in Line 15E: total aid paid (Line 12B) minus the nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (Line 15A) minus federal share (Line 15D) multiplied by 95 percent.
9. Line 15F - Enter the county share in Line 15F: total aid paid (Line 12B) minus federal share (Line 15D) minus state share (Line 15E).
10. Line 16C - Enter the total repayments as reported on the Repayment Contra Roll.
11. Line 16D, E and F - Enter federal, state and county shares of repayments determined in accordance with the federal, state, and county EA repayment sharing ratios.
12. Line 17 - Enter Grand Totals.
13. Line 18 and 19 - Reserved for the application of adjustments made by the state (federal and/or state field agent exceptions, etc.).
14. Lines 20 and 21 - included at county request and use is optional.

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of SOC 801

INSTRUCTIONS FOR USE OF FORM SOC 801

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 6 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary. (For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.) All money amounts on the Form SOC 801 may be rounded to the nearer dollar.
3. Enter the subtotals in Lines 6 and 10 and the totals in Line 12.
4. Line 13A - Determine amount of immediate need not subject to state participation.
5. Line 14D - Enter the federal share in Line 14D: total aid paid (Line 12B) multiplied by 50 percent.
6. Line 14E - Enter the state share in Line 14E: total aid paid (Line 12B) minus Immediate Need Payments not subject to state participation (Line 13A) minus federal share (Line 14D) multiplied by 89.2 percent.
7. Line 14F - Enter the county share in Line 14F: total aid paid (Line 12B) minus federal share (Line 14D) minus state share (Line 14E).
8. Line 15C - Enter the total repayments as reported on the Repayment Contra Roll.
9. Line 15D, E and F - Enter federal, state and county shares of repayments determined in accordance with the current federal, state, and county EA sharing ratios.
10. Line 16 - Enter Grand Totals.
11. Line 17 and 18 - Reserved for the application of adjustments made by the state (federal and/or state field audit exceptions, etc.)
12. Lines 19 and 20 - Included at county request and use is optional.

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- AD 800

State of California - Health and Welfare Agency Department of Social Services

CERTIFICATION - ADOPTION COST OF CARE SUBVENTION
UNDER W&IC 16106

FROM _____ COUNTY

FOR QUARTER ENDING _____, 19____ FISCAL YEAR
(For State Use Only)

Transfer to Form 1099 of the State Department of Social Services, 744 F Street, Sacramento 95814

1. Total Claimable Cost of Care Under W&IC 16106
(From Form AD 801A, Column 5) \$ _____

FOR STATE USE ONLY

I hereby certify, under penalty of perjury, that I am duly authorized to make this claim on behalf of the county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; and that the amounts claimed for cost of care have been expended in accordance with law, and the rules and regulations of the State Department of Social Services.

TITLE _____
DATE _____, 19____

I hereby certify, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; and that the records of this county indicate the amounts claimed are due and owing the county from the State of California according to law.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER
DATE _____, 19____

AD 800 (5/79)

**FISCAL MANAGEMENT AND CONTROL
FORMS**

Handbook

25-605 (Cont.)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- DFA 837

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY				DEPARTMENT OF SOCIAL SERVICES			
SUMMARY REPORT OF ASSISTANCE EXPENDITURES				FOR STATE USE ONLY			
Old Age Security, Aid to the Blind, and Aid to the Disabled				<input type="checkbox"/> SOSS <input type="checkbox"/> COUNTY WELFARE <input type="checkbox"/> COUNTY AUDITOR			
COUNTY _____				DATE _____			
A. OLD AGE SECURITY				1. Repayments (Federal 48%, State 37%, County 15%) 2. Adjustments (Refer to sharing ratio block below) 3. State use only line 4. Total			
Column 1	Column 2	Column 3	Column 4				
Total	Federal	State	County				
B. AID TO THE BLIND				1. Repayments (Federal 48%, State 37%, County 15%) 2. Adjustments (Refer to sharing ratio block below) 3. State use only line 4. Total			
Column 1	Column 2	Column 3	Column 4				
Total	Federal	State	County				
C. AID TO THE DISABLED				1. Repayments (Federal 48%, State 37%, County 15%) 2. Adjustments (Refer to sharing ratio block below) 3. State use only line 4. Total			
Column 1	Column 2	Column 3	Column 4				
Total	Federal	State	County				
FEDERAL PERCENTAGE BLOCK				5. Federal Percentage to be used for adjustments. (Use Nov. 1973 claims for OAS, AB, and ATD Federal percentages)			
OAS	AB	ATD					
SHARING RATIOS FOR ADJUSTMENTS				FEDERAL STATE COUNTY			
OAS	Federal % shown in above block X amount of the adjustment X 50%	Part A - Line 2 Col. 1 minus Col. 2 Part B - Line 2 Col. 1 minus Col. 2	County				
AB		Part C - Line 2 Col. 1 minus Col. 2 X 50%	Part C - Line 2 Col. 1 minus Col. 2 and Col. 3				
ATD							
I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Adult-Close Out Programs (Old Age Security, Aid to the Blind, and Aid to the Disabled) in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that all payments and collections reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.				I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with the law and the rules and regulations of the State Department of Social Services.			
COUNTY WELFARE DIRECTOR SIGNATURE _____		DATE _____		COUNTY AUDITOR OR COMPTROLLER SIGNATURE _____		DATE _____	
DFA 837 12/801							

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- Reverse of DFA 837

INSTRUCTIONS FOR USE OF FORM DFA 837

A. Enter county name and quarter and year of claim in space provided.

B. Line 1, Col. 1 -- Enter total repayments from Repayment Contra Rolls.

C. Line 1, Col. 2, 3, 4 -- Enter the federal, state and county share of repayments determined in accordance with ratio printed on Line 1.

D. Line 2, Col. 1 -- Enter the net amount of all other transactions.

E. Line 2, Col. 2, 3, 4 -- Enter the federal, state and county share of all other transactions using the sharing ratio applicable to the specific program.

F. Line 3 -- Reserved for the application of adjustments made by the state (Federal and/or State Field Audit Exceptions, etc.)

G. Line 4, Col. 1, 2, 3, 4 -- Enter grand totals.

**FISCAL MANAGEMENT AND CONTROL
FORMS**

Handbook

25-605 (Cont.)

25-605 FORMS (Continued)

25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- EL 800

<p>STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY</p>	<p>DEPARTMENT OF SOCIAL SERVICES</p> <p>Submit to: DEPARTMENT OF SOCIAL SERVICES CLAIMS AUDIT AND CONTROL BUREAU 794 P STREET, M.S. 18-15 SACRAMENTO, CALIFORNIA 95814</p>
<p>SUMMARY REPORT OF UNCOLLECTED LOANS (For Claiming Against the Emergency Revolving Fund)</p>	
<p>FOR STATE USE</p> <p><input type="checkbox"/> DSS <input type="checkbox"/> COUNTY WELFARE <input type="checkbox"/> COUNTY AUDITOR</p> <p>COUNTY _____ DATE (MONTH, YEAR) _____</p>	
<p>FISCAL YEAR 19 _____ (Third prior Fiscal Year and beyond)</p> <p>Uncollected Emergency Loans \$ _____</p> <p>Abatements \$ (_____)</p> <p>Amount of Reimbursement to County \$ _____</p>	
<p>FISCAL YEAR 19 _____ (Second prior Fiscal Year)</p> <p>Uncollected Emergency Loans \$ _____</p> <p>Abatements \$ (_____)</p> <p>Amount of Reimbursement to County \$ _____</p>	
<p>FISCAL YEAR 19 _____ (First prior Fiscal Year)</p> <p>Uncollected Emergency Loans \$ _____</p> <p>Abatements \$ (_____)</p> <p>Amount of Reimbursement to County \$ _____</p>	
<p>CURRENT FISCAL YEAR</p> <p>Uncollected Emergency Loans \$ _____</p> <p>Abatements \$ (_____)</p> <p>Amount of Reimbursement to County \$ _____</p>	
<p>TOTAL FOR CURRENT, FIRST PRIOR, AND SECOND PRIOR FISCAL YEARS</p> <p>Total Uncollected Emergency Loans \$ _____</p> <p>Total Abatements \$ (_____)</p> <p>Total Amount of Reimbursement to County \$ _____</p>	
<p>TOTAL FOR THIRD PRIOR FISCAL YEAR AND BEYOND</p> <p>Total Uncollected Emergency Loans \$ _____</p> <p>Total Abatements \$ (_____)</p> <p>Total Amount of Reimbursement to County \$ _____</p>	
<p><i>I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Emergency Loans in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the uncollected loans and abatements reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.</i></p>	<p><i>I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with law and the rules and regulations of the State Department of Social Services.</i></p>
<p>SIGNATURE OF COUNTY WELFARE DIRECTOR _____</p> <p>DATE _____</p>	<p>SIGNATURE OF COUNTY AUDITOR OR CONTROLLER _____</p> <p>DATE _____</p>
<p>EL 800 12/791</p>	

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V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES

CA 355

STATE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
DISTRICT ATTORNEY EMPLOYEE'S CHILD SUPPORT TIME STUDY FOR IV-D FUNCTIONS

PART I - EMPLOYEE INFORMATION

Name: _____ CLASSIFICATION: _____ GRADE: _____ MONTHS: _____

PART II - INSTRUCTIONS ON BACK OF FORM

PART III - DAILY TIME STUDY

ACTIVITIES	DAYS																															Grand Total	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
1. Administrative																																	
2. Collection and Distribution																																	
3. Establishment of Priority																																	
4. Location of Absent Parents																																	
5. Establishment of Support																																	
6. Enhancement of Support																																	
7. See Lines 3, 4, 5, and 6																																	
8. See Lines 1 through 6																																	
9. Non-Child Support																																	
10. Subtotal (Sum Lines 1-9 and 9)																																	
11. Unavailable																																	
12. DAILY GRAND TOTAL																																	

EMPLOYEE I hereby certify that this is a true and accurate report of my time, and the function performed as shown above.

SIGNATURE OF EMPLOYEE DATE

SUPERVISOR I hereby certify the employee's daily time records have been examined and that, to the best of my knowledge and belief, the time record is true and correct, and the functions were performed as shown above.

SIGNATURE OF SUPERVISOR DATE

CS 88-0088

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

Reverse of CA 355

PART I INSTRUCTIONS	PART II	
<p>STAFF REQUIRED TO TIME STUDY</p> <p>Time studies are to be completed by:</p> <ol style="list-style-type: none"> 1. All District Attorney staff engaged in AFDC and non-AFDC related child support casework. This would include District Attorney employees outside the Family Support Division who bill the Family Support Division for time spent in child support activities. 2. Employees of other county agencies who bill the Family Support Division for child support activities. 3. Personnel normally required to time study include: <ol style="list-style-type: none"> a. District Attorneys and Deputy District Attorneys (when actively engaged in casework). b. Investigators c. Interviewers d. First Line Supervisors e. SECF Processing staff <ol style="list-style-type: none"> (1) First Line Supervisors (2) Clerical Staff f. Budget Computation Staff <p><i>Time studies are optional for certain clerical personnel and for certain supervisors above the first line of supervision (see Fiscal Manual 25-865.23 and 25-865.24).</i></p> 	<p>ACTIVITY DEFINITIONS</p> <ol style="list-style-type: none"> 1. Administration – Activities of personnel engaged in the administration of the Child Support Enforcement Program. These activities include workload planning, program review, budget preparation, Family Support Council Meetings, execution of agreements with public and private providers, etc. District Attorneys, and administrative officers normally record time in this activity. 2. Collection and Distribution – These are the activities of staff members engaged in the processing of child support collection. These activities include the processing of child support payments, completion of returns, part-ns, and preparation of Forms 10-500 and CS 100. DA and Welfare staff processing and distributing Child Support payments normally are not time in this activity. 3. Establishment of Paternity – Activities of staff members engaged in the determination of paternity in child support cases. Typical activities would include investigation, registration of polygraph and blood tests, making referrals to other states and counties, time in court, and cooperating with other states and counties to establish paternity in child support cases. 4. Location of Absent Parents – Activities undertaken by staff members to locate parents who have deserted their families. Activities would include investigation leading to location, utilization of the Parent Locator Service and making referrals to other state and local agencies. 5. Establishment of Support Obligation – Activities of staff members related to determining the ability of an absent parent to support his family, bringing court actions to secure child support orders. 	<ol style="list-style-type: none"> 4. Enforcement of Support Obligation – Activities of staff members enforcing support obligations through appropriate legal remedies, including IRS, FTB AND UIF intercept systems, etc. This activity also includes investigations and prosecution of fraud related to child support. 7. Non-AFDC – Any child support activities related to cases which are not linked to an aid program. 8. Non-Child Support – Any activities by staff members not related to the child support program such as welfare fraud, and issuing disregard payments, notices and disregard inquiries. Separate disregard activities from other activities on Line 5c, to allow reimbursement from the DA agency. <p>SPECIAL INSTRUCTIONS</p> <ol style="list-style-type: none"> 1. Record time in 15 minute increments (e.g. 3.25 hours, 3.50 hours, 3.75 hours). 2. Time spent on coffee breaks, to be charged as nonallocable along with vacation and sick leave. 3. Holiday time should be treated as weekends. 4. All full time employees participating in time study must show a total of 8 hours of time per working day. No overtime should be included. 5. Charge travel time to the activity with which it is associated. 6. Percentage of time spent should be based on nothing subtotal on Line 10 against each item 1 through 9 (a and b) not daily grand total against these items.

SAMPLE

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.1

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY					DEPARTMENT OF SOCIAL SERVICES		
IV-D CHILD SUPPORT EXPENDITURE SCHEDULE AND CERTIFICATION					COUNTY	SUN (A) (MGA)	
<i>Please round all figures to nearest dollar. If additional space is needed, attach a separate sheet.</i>							
					ALLOCABLE COSTS	DIRECT COSTS	TOTAL
					Column 1	Column 2	Column 3
A. PERSONAL SERVICES — LOCAL IV-D AGENCY (Non EDP)							
1. Casework Staff (Legal, Investigative, etc.)					\$ _____	\$ _____	
2. Administrative Support					\$ _____	\$ _____	
3. Clerical Support					\$ _____	\$ _____	
TOTAL IV-D AGENCY PERSONAL SERVICES					\$ _____	\$ _____	\$ _____
B. OPERATING COSTS — LOCAL IV-D AGENCY (Non EDP)							
1. Space (itemize)					\$ _____		
_____					\$ _____		
2. Personal Property (Non EDP Equipment)					\$ _____		
3. Training and Travel					\$ _____		
4. Microlfilm					\$ _____		
5. Other Operating Costs					\$ _____		
TOTAL IV-D AGENCY OPERATING COSTS					\$ _____		\$ _____
C. INDIRECT COSTS — LOCAL IV-D AGENCY							
1. Approved Indirect Cost Rate (_____ %)					\$ _____		
2. Countywide Overhead (FMC 74-4/A-8)					\$ _____		
TOTAL IV-D AGENCY INDIRECT COSTS					\$ _____		\$ _____
D. PURCHASE OF SERVICES/COOPERATIVE AGREEMENTS (Non EDP)							
(itemize)							
Agency	Code	Personal Services	Operating Costs	Indirect Costs	\$ _____	\$ _____	
_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	
_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	
_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	
_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	
TOTAL PURCHASE OF SERVICE COSTS					\$ _____	\$ _____	\$ _____

25-605 FORMS (Continued)

25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.2

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY					DEPARTMENT OF SOCIAL SERVICES		
IV-D CHILD SUPPORT EXPENDITURE SCHEDULE AND CERTIFICATION					County	Subunit (FMS#)	
Please round all figures to nearest dollar. If additional space is needed, attach a separate sheet.					ALLOCABLE COSTS	DIRECT COSTS	TOTAL
					Column 1	Column 2	Column 3
A. PERSONAL SERVICES — LOCAL IV-D AGENCY (Non EDP)							
1. Casework Staff (Legal, Investigative, etc.)					\$	\$	
2. Administrative Support					\$	\$	
3. Clerical Support					\$	\$	
TOTAL IV-D AGENCY PERSONAL SERVICES					\$	\$	\$
B. OPERATING COSTS — LOCAL IV-D AGENCY (Non EDP)							
1. Space (Itemize)					\$	\$	
2. Personal Property (Non EDP Equipment)					\$	\$	
3. Training and Travel					\$	\$	
4. Microlfilm					\$	\$	
5. Other Operating Costs					\$	\$	
TOTAL IV-D AGENCY OPERATING COSTS					\$	\$	\$
C. INDIRECT COSTS — LOCAL IV-D AGENCY							
1. Approved Indirect Cost Rate (%)					\$	\$	
2. Countywide Overhead (FMC 74-4/A-B)					\$	\$	
TOTAL IV-D AGENCY INDIRECT COSTS					\$	\$	\$
D. PURCHASE OF SERVICES/COOPERATIVE AGREEMENTS (Non EDP)							
(Itemize)							
Agency	Code	Personal Services	Operating Costs	Indirect Costs	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
TOTAL PURCHASE OF SERVICE COSTS					\$	\$	\$

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.3

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

COURT: _____ QUARTER ENDING _____

IV—D CHILD SUPPORT TIME SUMMARY AND ACTIVITY ALLOCATION RATIOS

LINE	ACTIVITIES	TOTAL ALLOCABLE HOURS	ALLOCATION RATIO
	1	2	3
A	Administration		
B	Collection and Distribution		
C	Establishment of Paternity		
D	Location of Absent Parent		
E	Establishment of Support		
F	Enforcement of Support		
G	Non-Child Support	Disability	
		Other	
H	GRAND TOTAL HOURS	2'	1.000000

1' For Lines A through F, accumulate monthly totals of all hours (AFDC and Non-AFDC) by activity from Grand Total Column of CS 355's. Line G, items a and b must agree with Line 9, a and b of the CS 355's.

2' Enter monthly total of all hours recorded on Line 10 of CS 355's.

3' Ratios are obtained by dividing hours recorded in each activity by Grand Total Hours Line H, Column 2.

MODIFICATION A COMPUTATION OF AFDC AND NON-AFDC HOURS

LINE	Hours	Ratio
	1	2
A	AFDC 4'	
B	Non-AFDC 5'	
C	TOTAL 6'	

4' Enter monthly total of AFDC related hours recorded on Lines 3, 4, 5 and 6 of CS 355's.

5' Enter monthly total of Non-AFDC related hours recorded on Lines 3, 4, 5 and 6 of CS 355's.

6' Enter the sum of Lines A and B.

7' Divide hours on Lines A and B by hours recorded on Line C.
Transfer ratios recorded in Column 2 to MODIFICATION B, CS 356.7.

CS 256 3/10 85; FORMERLY CA 256

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.4

IV-D CHILD SUPPORT PROGRAM DISTRIBUTION TOTAL ALLOCABLE COSTS												
Activities	Ratio 1/	LOCAL IV-D AGENCY			PURCHASE OF SERVICES 2/			ELECTRONIC DATA PROCESSING 3/			TOTALS	
		Personal Services	Operating Costs	Indirect Costs	Personal Services	Operating Costs	Indirect Costs	Personal Services	Operating Costs	Indirect Costs		
		CS 356.1, A, Col. 1 times Col. 2 ratio	CS 356.1, B, Col. 1 times Col. 2 ratio	CS 356.1, C, Col. 1 times Col. 2 ratio	CS 356.1, D times Col. 2 ratio	CS 356.1, E times Col. 2 ratio	CS 356.1, F times Col. 2 ratio	CS 356.2, G times Col. 2 ratio	CS 356.2, H times Col. 2 ratio	CS 356.2, I times Col. 2 ratio		Sum of 4/ & 5/ times 1/
1	2	3	4	5	6	7	8	9	10	11	12	
A Administration												
B Collection and Enforcement												
C Establishment of Paternity												
D Location of Adult Parent												
E Establishment of Support												
F Enforcement of Support												
G Non-Child Support	a. Disputed											
	b. Other											
H TOTALS	1.000000											4/

1/ - Bring ratios forward from CS 356.3, Column 3.
2/ - Prepare subtotals of only those costs reported as Allocable in Column 1, on the CS 356.1, Group D, and transfer to the appropriate Column 6, 7 and 8.
3/ - Prepare subtotals of only those costs reported as Allocable in Column 1, on the CS 356.2, Group E, and transfer to the appropriate Column 9, 10 and 11.
4/ - This total must agree with CS 356.2, Group H, Column 1.

**FISCAL MANAGEMENT AND CONTROL
FORMS**

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25-605 (Cont.)

25-605 FORMS (Continued)

25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.5

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

**IV-D CHILD SUPPORT PROGRAM DISTRIBUTION
DIRECT COSTS (Excluding Lab costs)**

County: _____ Submitter: _____

1) 2) 3)	LOCAL IV-D AGENCY			PURCHASE OF SERVICES 1)			ELECTRONIC DATA PROCESSING 2)			Allocation	Totals	
	Personal Services CS 347 Col. 4	Operating Costs CS 348 Col. 5	Indirect Costs CS 349 Col. 6	Personal Services CS 354.1 D Col. 7	Operating Costs CS 354.1 D Col. 8	Indirect Costs CS 354.1 D Col. 9	Personal Services CS 354.2 Col. 10	Operating Costs CS 354.2 Col. 11	Indirect Costs CS 354.2 Col. 12			CS 354.2 Col. 13
A	Administration											
B	Collection and Distribution											
C	Establishment of Paternity											
D	Location of Absent Parent											
E	Establishment of Support											
F	Enforcement of Support											
G	Total											

1) Prepare subtotals of only those costs reported as Direct in Column 2, on the CS 354.1, Group D, and transfer to appropriate Column 5, 8, and 9.

2) Prepare subtotals of only those costs reported as Direct in Column 2, on the CS 354.2, Group E, and transfer to appropriate Column 10, 11, and 12.

CS 356.5 (1/88)

**FISCAL MANAGEMENT AND CONTROL
FORMS**

25-605 (Cont.)

Handbook

25-605 FORMS (Continued)

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V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.6

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

IV-D CHILD SUPPORT PROGRAM DISTRIBUTION
TOTAL ALLOCABLE AND DIRECT COSTS (Excluding Lab costs)

COST: _____ SUBTOTAL: _____

I II III IV V VI VII VIII IX X XI XII	Activity	LOCAL IV-D AGENCY			PURCHASE OF SERVICES			ELECTRONIC DATA PROCESSING			Subtotal	Allocations	Totals
		Personnel Services MCA, Sec. 1 Part 100, Sec. 1	Operating Costs MCA, Sec. 1 Part 100, Sec. 1	Indirect Costs MCA, Sec. 1 Part 100, Sec. 1	Personnel Services MCA, Sec. 1 Part 100, Sec. 1	Operating Costs MCA, Sec. 1 Part 100, Sec. 1	Indirect Costs MCA, Sec. 1 Part 100, Sec. 1	Personnel Services MCA, Sec. 1 Part 100, Sec. 1	Operating Costs MCA, Sec. 1 Part 100, Sec. 1	Indirect Costs MCA, Sec. 1 Part 100, Sec. 1			
		1	2	3	4	5	6	7	8	9	10	11	12
A	Administration												
B	Collection and Distribution												
C	Establishment of Paternity												
D	Location of Absent Parent												
E	Establishment of Support												
F	Enforcement of Support												
G	Subtotal												
H	Non-Child Support & Other												
I	TOTALS												

SAMPLE

**FISCAL MANAGEMENT AND CONTROL
FORMS**

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25-605 (Cont.)

25-605 FORMS (Continued)

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V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.7

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES		
IV-D CHILD SUPPORT PROGRAM DISTRIBUTION REPORT OF TOTAL EXPENDITURES				
		COUNTY	QUARTER ENDING	
L I N E	Activities	EXPENDITURES FOR THE QUARTER (Round to nearest dollar)		
		Total 1/	Federal 2/	County 3/
		1	2	3
A	Administration	01		03
B	Collection and Distribution	04		06
C	Establishment of Paternity	07		09
D	Location of Absent Parent			12
E	Establishment of Support		14	15
F	Enforcement of Support		17	18
G	Subtotal		20	21
H	Non-Child Support	22		23
		24		25
I	Laboratory Co.	26	4/ 27	5/ 28
J	TOTAL DISTRICT	29	6/ 30	31
K	SUPERIOR COURT SYSTEM—EXPEDITED PROCESS	32	7/ 33	34
L	GRAND TOTAL 8/	35	36	37

1/ Bring figures forward from CS 356.6, Column 13 (except Lines I, J, and K).
 2/ Multiply Column 1, Lines A through G and Line K by the Federal Financial Participation Rate applicable for this period.
 3/ County Share is Column 1 less Column 2.
 4/ Bring figure forward from CS 356.2, Group F, Column 3.
 5/ Multiply column 1 by 90% special Federal Financial Participation Rate.
 6/ Total must agree with CS 356.2, Group H, Column 3.
 7/ Bring figure forward from CS 356.6, Group I, Column 3.
 8/ Column 1 should agree with CS 356.2, Group J, Column 3.

These two Modifications are for statistical reporting purposes only. They have no effect on your claim.

MODIFICATION B - AFDC AND NON AFDC IDENTIFICATION			
L I N E	Identification	Rate	Child Support Costs 11/
	1	2	3
A	AFDC 8/ 08		09
B	NON AFDC 16/ 40		41
C	TOTAL	1.000000	42

8/ Bring ratio forward from CS 356.3, Mod A, Column 2, Line A.
 10/ Bring ratio forward from CS 356.3, Mod A, Column 2, Line B.
 11/ Multiply Column 2 ratios by Child Support Costs, Subtotal above, Line G, Column 1.
 12/ All expenditure items for Mod C, are obtained from CS 356.6, Subtotal, Line G, Columns 2 through 11, and Column 13.
 13. Bring figure forward from CS 356.2, Group F, Column 3.

MODIFICATION C—SPECIFIC EXPENDITURE ITEM SUMMARY 12/				
L I N E	Expenditure Item 12/	Personal Services 2/	Operating Costs 3/	Indirect Costs 4/
	1	2	3	4
A	Local IV-D	43	44	45
B	Purchase of Services	46	47	48
C	EDP	49	50	51
D	Lab costs		52	53
E	Abatements		53 ()	
F	TOTAL	54	55	56

CS 356.7 (1/88)

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.8

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

COUNTY: _____ QUARTER ENDING: _____

IV-D CHILD SUPPORT PROGRAM — PERSONAL SERVICES

These two modifications are for statistical reporting purposes only. There is no fiscal effect on the claim.

MODIFICATION D — EDP PERSONAL SERVICES

L I N E	SOURCE	EDP PERSONAL SERVICES ^{1/}	RATIO ^{2/}
		COLUMN 1	COLUMN 2
A	LOCAL IV-D AGENCY		
B	PURCHASE OF SERVICES		
C	TOTAL		0000000

1/ Figures from CS 356.2, Part 5, Personal Services Column
2/ Divide Column 1, Line A, by Column 1, Line C
Divide Column 1, Line B, by Column 1, Line C

MODIFICATION E — PERSONAL SERVICES

L I N E	SOURCE	LOCAL IV-D AGENCY	PURCHASE OF SERVICES	TOTAL
		COLUMN 1	COLUMN 2	COLUMN 3
A	EDP PERSONAL SERVICES	^{3/}	^{4/}	
B	OTHER PERSONAL SERVICES	^{5/}	^{6/}	
C	GRANT TOTAL			^{7/}

3/ Multiply the Ratio from MOD. D, Column 2, Line A Times MOD. C, Line C, Column 2.
4/ Multiply the Ratio from MOD. D, Column 2, Line B Times MOD. C, Line C, Column 2.
5/ Figure from MOD C, Line A, Column 2.
6/ Figure from MOD. C, Line B, Column 2.
7/ This Grant Total Must Equal MOD. C, Line F, Column 2.

CS 356 8/12/86

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 357

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

**GROUP A INDIVIDUAL EMPLOYEE WORKSHEET
LOCAL IV-D AGENCY - DIRECT COSTS**

Use of this form is required for claiming any Direct Group A costs on the CS 356.1.

	DATE	FISCAL YEAR	QUARTER ENDING
	EMPLOYEE NAME		CLASSIFICATION
	TOTALS		
A. 1. Child Support Hours			
2. Total Hours	=		
3. Child Support Percentage	%		
B. 1. Child Support Percentage (A. 3)			
2. Quarterly Personal Services (Salaries and Benefits)	= \$		
3. Claimable Personal Services	= \$		
C. 1. Claimable Personal Services			
2. Indirect Cost Rate (Employee Division Rate)	%		
3. Claimable Indirect Costs	= \$		
D. 1. Claimable Personal Services	= \$		
2. Claimable Indirect Costs (C. 3)	= \$		
3. Total Claimable Costs	= \$		1/

Activities	Total Child Support Hours 2	Ratios 3	PERSONAL SERVICES	INDIRECT COSTS
			Claimable Personal Services (B. 3. times Column 3 ratio) 4	Claimable Indirect Costs (C. 3. times Column 3 ratio) 5
Administration				Line A
Collection and Distribution				Line B
Establishment of Paternity				Line C
Location of Absent Parent				Line D
Establishment of Support				Line E
Enforcement of Support				Line F
Total		1.000000		Line G

1/ This cost will be reported on CS 356.1, Group A, Column 2.

2/ Ratios are obtained by dividing hours recorded in each activity by Total hours recorded in Column 2.

3/ Transfer costs recorded in each activity to CS 356.5, Column 3, Lines A through G.

4/ Transfer costs recorded in each activity to CS 356.5, Column 4, Lines A through G.

CS 357 (10/98)

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**FISCAL MANAGEMENT AND CONTROL
FORMS**

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25-605 (Cont.)

25-605 FORMS (Continued)

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VII. CHILD SUPPORT INCENTIVE CLAIMS (See Chapter 25-900)

CS 278L

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY														
CHILD AND SPOUSAL SUPPORT CASE HISTORY AND LIST OF AUTHORIZATIONS														
RECIPIENT:				STATE	STATE CASE NUMBER					COUNTY				
ABSENT PARENT:				NAME	SOCIAL SECURITY NUMBER									
SUPPORT OBLIGATION:				CURRENT DOLLARS \$	DATE OF COURT ORDER									
Monthly Transaction Number	Date of Collection	Amount of Collection	Mo./Yr.	Assistance Paid	Current Recoupment	Prior Recoupment	Disregard	Pass-on	Excess	Unreimbursed Assistance	Unreimbursed Assistance Pool	Authorized By		
												Initial	Date	

SAMPLE

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 278M

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES		DEPARTMENT OF SOCIAL SERVICES	
CHILD AND SPOUSAL SUPPORT TRANSMITTAL/ACTION DOCUMENT			
A. COLLECTION AGENCY INFORMATION		STATE CASE NUMBER _____	
WOLFEY TRANSFER/ID NUMBER _____		_____	
1(A) COUNTY NAME AND CODE _____		1(B) COLLECTING AGENCY NAME AND CODE _____	
2(A) ABSENT PARENT INFORMATION - ABSENT PARENT NAME _____		2(B) ABSENT PARENT'S SOCIAL SECURITY NUMBER _____	
3(A) COMPANION CASES _____			
3(B) RECIPIENT INFORMATION - PAYER NAME _____			
TOTAL (Column 1)			
4. Amount of Collection	\$ _____		
4(a) Amount of Current Obligation	\$ _____		
4(b) Amount of Assigned Arrearages	\$ _____		
4(c) Date of Court Order _____		4(d) Ongoing Collection	_____
B. DISTRIBUTION AGENCY ACTION DOCUMENT			
1. TOTAL COLLECTIONS (SEE 2(A) ABOVE)	\$ _____	2(A) APPLIANCE	\$ _____
2. CURRENT OBLIG.	\$ _____	2(B) IF APPLICABLE	\$ _____
		<input type="checkbox"/> Emergency Assistance Case FC <input type="checkbox"/> Emergency Assistance U	
2(a) Assistance Paid	\$ _____		
2(b) Current Collection	\$ _____	Section B, Line 1(a).	
2(c) Disregard	\$ _____		
2(d) Collection Remaining	\$ _____	Section B, Line 2(b) minus 2(c).	
2(e) Recoupment	\$ _____	Section B, Line 2(a) or 2(d), whichever is less.	
2(f) Pass-on	\$ _____	Section B, Line 2(d) minus Line 2(e), if amount of Line 2(d) exceeds Line 2(e).	
2(g) Unreimbursed Assistance	\$ _____	Section B, Line 2(a) minus Line 2(d).	
3. Recoupment of Prior Months Unreimbursed Assistance			
3(a) Unreimbursed Assistance	\$ _____		
3(b) Arrearage Collection	\$ _____	Section B, Line 1(b).	
3(c) Recoupment	\$ _____	Section B, Line 3(a) or 3(b), whichever is less.	
3(d) Unreimbursed Assistance Remaining	\$ _____	Section B, Line 3(a) minus Line 3(c).	
3(e) Express	\$ _____	Section B, Line 3(b) minus Line 3(c).	
C. PAYMENT INFORMATION			
NAME OF PAYER _____			
ADDRESS _____			
PAYMENT AMOUNT	DEFERRED	PASS-ON	EXCESS
\$ _____	\$ _____	\$ _____	\$ _____
SIGNATURE OF SUBJECT CLAIMANT _____			DATE _____
CS 278M (3/78) Revises Form - Substitute Payment			

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 800

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

SUMMARY REPORT OF CHILD AND SPOUSAL SUPPORT PAYMENTS
(Round all figures to the nearest dollar.)

Family Group (FG) Federal Foster Care (FC) Federal
 Family Group (FG) Non-Federal Foster Care (FC) Non-Federal
 Unemployed (U) Federal Emergency Assistance (EA) (FC)
 Unemployed (U) Non-Federal Emergency Assistance (EA) (U)

FOR STATE USE
 DEL COUNTY OF L.A. COUNTY OF ALBANY COUNTY OF ALTA COUNTY OF BUTTE
 COUNTY CODE _____
 MONTH _____

CLAIMANT: _____ MONTH YEAR _____ PAYING TO BY: _____ PHONE: () _____

A. COLLECTIONS AND DISBURSEMENT	COLUMN 1 INTRACOUNTY		COLUMN 2 INTERCOUNTY		COLUMN 3 INTERSTATE		COLUMN 4 TOTAL Columns 1 thru 3
	Distribution	Case Counts	Distribution	Case Counts	Distribution	Case Counts	
1. Amount collected for disbursement							a b
2. Disregard remitted to family							c d
3. Pass-on remitted to family							e f
4. Excess remitted to family							g h
5. Total recoupment							i j

B. RECOUPMENT - CURRENT AND PRIOR

1. Current	ICS B(1)	ICS B(1)
2. Prior	ICS B(1)	ICS B(1)
3. Total Recoupment	IColumn 4, Line 5)	

TO BE COMPLETED AT COUNTY OPTION

C. REPAYMENT COMPUTATION

	FEDERAL	STATE	COUNTY	TOTAL (Columns 1 thru 3)
1. Recoupment only (Column 4, Line AS x Recoupment Rates)				

D. INCENTIVE COMPUTATION

	For Claiming County (Column 1 + Column 3)	To Collecting County (Column 2)
1. Section A, Line 1 x Federal AFDC Incentive (Federal FG, U, FC and EA programs)		
2. Section A, Line 1 x State AFDC Incentive (Federal FG, U, FC, EA and Non-Federal FG and U programs)		
3. Section A, Line 1 x Federal Non-AFDC Incentive (Non-Federal FG, U and FC programs)		

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the distribution of AFDC Child Support Collections in and for aforesaid county; that I have not violated any of the provisions of Sections 1050 to 1056, inclusive, of the Government Code; that the distribution of child support collections reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1050 to 1056, inclusive, of the Government Code; that the amounts reflected herein are in accordance with authorizations for the Child Support Enforcement Program made by the county; that said amounts correctly reflect proper distribution and that warrants therefore have been issued according to law and the rules and regulations of the State Department of Social Services.

SIGNATURE OF COUNTY OR DISTRICT ATTORNEY _____ DATE _____ SIGNATURE OF COUNTY AUDITOR OR CONTROLLER _____ DATE _____

CS 800 (7-88)

25-605 FORMS (Continued)

25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 801

STATE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES CHILD AND SPOUSAL SUPPORT PAYROLL FORM FOR COLLECTIONS AND DISBURSEMENT <small>FOR USE AND THIS FORM FOR REPORTING REVENUES MADE PRIOR TO JAN. 1, 1979</small>												
			COLLECTION BY: <input type="checkbox"/> WITHIN-COUNTY <input type="checkbox"/> INTER-COUNTY <input type="checkbox"/> INTERSTATE			EMPLOYER'S NAME						
STATE CLAIM NUMBER		PAIDEE NAME		AGENCY PAYEE		SOCIAL SECURITY NUMBER		ADDRESS		CITY AND STATE		
Collection and Disbursement Total												
Cash Count												
11-97712 (08-88) CLAIM FORM - SUBJECT PROVIDED												

25-605 FORMS (Continued)

25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 801A

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY		DEPARTMENT OF SOCIAL SERVICES					
SUMMARY CS 800 RECONCILIATION - INTRACOUNTY/INTERSTATE							
					COUNTY	MONTH/YEAR	
	AMOUNT COLLECTED FOR DISBURSEMENT	DISREGARD	PASS-ON	EXCESS	TOTAL RECOUPMENT	TOTAL RECOUPMENT CURRENT	PRIOR
INTRACOUNTY							
Family Group (FG) Federal							
Family Group (FG) Non-Federal							
Unemployed (U) Federal							
Unemployed (U) Non-Federal							
Foster Care (FC) Federal							
Foster Care (FC) Non-Federal							
Emergency Assistance (EA) (FC)							
Emergency Assistance (EA) (U)							
INTERSTATE							
Family Group (FG) Federal							
Family Group (FG) Non-Federal							
Unemployed (U) Federal							
Unemployed (U) Non-Federal							
Foster Care (FC) Federal							
Foster Care (FC) Non-Federal							
Emergency Assistance (EA) (FC)							
Emergency Assistance (EA) (U)							

CS 801A (7-88)

SAMPLE

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 820

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

FOR STATE USE ONLY

DSS COUNTY AUDITOR DISTRICT ATTORNEY

COUNTY CODE _____

MONTH _____

CHILD/SPOUSAL SUPPORT COLLECTIONS SUMMARY REPORT

COUNTY _____

MONTH/YEAR _____

CONTACT NAME _____

TELEPHONE _____

A. COLLECTIONS
Items 1-10: Do not include collections received from other jurisdictions.

	COLUMN I	COLUMN II	COLUMN III
	AFDC	Foster Care	Non-AFDC
1. Collections made through IRS Tax Offset:			
a. For any California county	01 \$	02 \$	03 \$
b. For other state IV-D agencies	04 \$	05 \$	
2. Collections made through FTB Offset:			
a. For any California county	07 \$	08 \$	
b. For other state IV-D agencies	10 \$	11	
3. Collections made through UIB Offset:			
a. For any California county	13 \$		
b. For other state IV-D agencies	16 \$		18 \$
4. Collections made through withholdings:			
a. For any California county			21 \$
b. For other state IV-D agencies			24 \$
5. Collections made through liens:			
a. For any California county		26 \$	27 \$
b. For other state IV-D agencies		29 \$	30 \$
6. Collections made through Workers' Compensation:			
a. For any California county	31 \$	32 \$	33 \$
b. For other state IV-D agencies	34 \$	35 \$	36 \$
7. Collections made through Disability Insurance:			
a. For any California county	37 \$	38 \$	39 \$
b. For other state IV-D agencies	40 \$	41 \$	42 \$
8. All other collections:			
a. For any California county	43 \$	44 \$	45 \$
b. For other state IV-D agencies	46 \$	47 \$	48 \$
9. Adjustments to previously reported collections:			
a. For any California county	49 \$	50 \$	51 \$
b. For other state IV-D agencies	52 \$	53 \$	54 \$

CS 820 (10/88) (Continued on Reverse)

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

Reverse of CS 820

	AFDC	Foster Care	Non-AFDC
10. Total collections:			
a. For any California county	55 \$	56 \$	57 \$
Count	58	59	60
b. For other state IV-D agencies	61 \$	62 \$	
Count	64	65	
11. Collections received:			
a. From other California counties	67 \$	68 \$	
Count	70	71	
b. From other state IV-D agencies	73 \$		\$
Count	76		78
12. Total intracounty collections:	79 \$		81 \$
Count	82		84
13. Payments to non-AFDC families			85 \$
Count			86
14. Collections for terminated AFDC cases (Combine collections made for and received from all jurisdictions)			87 \$
Count			88
15. Collections for non-federal foster care			89 \$
Count			90

B. COLLECTIONS ELIGIBLE FOR INCENTIVES

16. Federal AFDC — Cols. I & II, 10b = _____

17. Federal non-AFDC — Col. III, 10b + 13 = _____

18. State non-AFDC — Col. III, 13 = _____

FOR STATE USE ONLY

FEDERAL:		STATE:	
AFDC	Non-AFDC	State	Non-AFDC
Federal Line 16 x Incentive	Federal Line 17 x Incentive	State Line 18 x Incentive	

<p><small>I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the collection of support payments under the title IV-D Program in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 and 1096, inclusive, of the Government Code; that the disbursement of support collections reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.</small></p> <p>_____ SIGNATURE OF DISTRICT ATTORNEY</p> <p>_____ DATE</p>	<p><small>I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts reflected herein are in accordance with authorizations for the Child Support Enforcement Program made by the county; and that warrants thereto have been issued according to law and the rules and regulations of the State Department of Social Services.</small></p> <p>_____ SIGNATURE OF COUNTY AUDITOR OR CONTROLLER</p> <p>_____ DATE</p>
--	--

FISCAL MANAGEMENT AND CONTROL
FORMS

Handbook

25-605 (Cont.)

25-605 FORMS (Continued)

25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 821

SUPPORT COLLECTION REPORT

Intracounty Collections Intercounty Collections For California Counties From California Counties Interstate Collections For Other State IV-D Agencies From Other State IV-D Agencies Status AFDC Foster Care Non-AFDC Nonfederal Foster Care Jurisdiction FIPS Code _____

County _____ Page _____
Month _____ Year _____

Adjustments

COUNTY ID NUMBER	CASE NAME (OP/TOTAL)	TRANSACTION NUMBER	TOTAL COLLECTION	AMOUNT COLLECTED								
				MS	FIB	US	WITHHOLDING	UNIS	WORKER'S COMPENSATION	DISABILITY INSURANCE	ALL OTHER COLLECTIONS	REPAYMENT AFDC
SAMPLE												
TOTAL												

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 822

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

SUMMARY CS 820 RECONCILIATION STATEMENT

INTERCOUNTY/INTERSTATE — COLLECTIONS MADE BY REPORTING COUNTY FOR THE OTHER CALIFORNIA COUNTIES AND FOR OTHER STATE IV-D AGENCIES.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____ 19____ CS 820.

	INTRACOUNTY	INTERCOUNTY	TOTAL INTRA/ INTERCOUNTY	INTERSTATE
IRS:				
AFDC	\$	\$	\$	
FOSTER CARE				
NON-AFDC				
FTB:				
AFDC				
FOSTER CARE				
NON-AFDC				
UIB:				
AFDC				
FOSTER CARE				
NON-AFDC				
WITHHOLDING:				
AFDC				
FOSTER CARE				
NON-AFDC				
LIENS:				
AFDC				
FOSTER CARE				
NON-AFDC				
WORKER'S COMPENSATION:				
AFDC				
FOSTER CARE				
NON-AFDC				
DISABILITY INSURANCE:				
AFDC				
FOSTER CARE				
NON-AFDC				
ALL OTHER COLLECTIONS:				
AFDC				
FOSTER CARE				
NON-AFDC				
ADJUSTMENTS:				
AFDC				
FOSTER CARE				
NON-AFDC				
TOTAL COLLECTIONS:	\$	\$	\$	\$
AFDC				
COUNT				
FOSTER CARE	\$	\$	\$	\$
COUNT				
NON-AFDC	\$	\$	\$	\$
COUNT				

(Continued on Reverse)

CA 822 (1/88)

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

Reverse of CS 822

INTERCOUNTY/INTERSTATE — COLLECTIONS RECEIVED BY REPORTING COUNTY FROM OTHER CALIFORNIA COUNTIES AND OTHER STATE IV-D AGENCIES.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19____ CS 820.

	INTERCOUNTY	INTERSTATE
AFDC	\$ _____	\$ _____
COUNT	_____	_____
FOSTER CARE	\$ _____	\$ _____
COUNT	_____	_____
NON-AFDC	\$ _____	\$ _____
COUNT	_____	_____

PAYMENTS TO NON-AFDC FAMILIES - Payments made to Families Not Receiving Public Assistance.

Data obtained from _____, Pages _____ Through _____

NON-AFDC Payments to families \$ _____ Count _____

PAYMENTS FOR TERMINATED AFDC CASES - Collections made by reporting and county and received from other jurisdictions on behalf of families who are former recipients of aid and for whom collections are being made for a 5 month period.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19____ CS 820.

Payments for terminated AFDC cases \$ _____ Count _____

NON-FEDERAL FOSTER CARE COLLECTIONS - Collections made by reporting county on behalf of non-federal foster care children.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19____ CS 820.

Non-Federal foster care payments \$ _____ Count _____

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**FISCAL MANAGEMENT AND CONTROL
FORMS**

Handbook

25-605 (Cont.)

25-605 FORMS (Continued)

25-605

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (see Chapter 25-400)

ABCD 830

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

OVERPAYMENT RECEIVABLE RECORD

CASE NAME: _____ CASE NUMBER: _____ DISTRICT: _____

ADDRESS: _____ ELIGIBILITY WORKER: _____

A. SUMMARY OF OVERPAYMENT/UNDERPAYMENT

MO/YR	AMOUNT	MO/YR	AMOUNT	MO/YR	AMOUNT	MO/YR	AMOUNT	
1.	\$	4.	\$	7.	\$	10.	\$	
2.	\$	5.	\$	8.	\$	11.	\$	
3.	\$	6.	\$	9.	\$	12.	\$	
							1. Net total amount (Items 1 thru 12)	\$
							2. Amount to be recovered by grant adjustment	\$
							3. Amount to be recovered by voluntary cash recovery	\$

B. OVERPAYMENT DATA

1. Recipient Met Reporting Responsibility _____ Recipient did not Meet Reporting Responsibility _____
 Date of Fair Hearing _____ Date of Discovery/Fair Hearing _____

2. Reason for Overpayment
 Recipient Error _____
 Agency Error _____

C. SCHEDULE OF RECOVERY PLAN AND ACTUAL PAYMENTS RECEIVED

Grant Adjustments

MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.	
1				5				9				
2				6				10				
3				7				11				
4				8				12				
											Total Grant Adjustments Received - Items 1 thru 12 →	\$

Voluntary Cash Recovery

MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.	
1				5				9				
2				6				10				
3				7				11				
4				8				12				
											Total Voluntary Cash Recovery Received - Items 1 thru 12 →	\$

D. COMPUTATION OF UNRECOVERED OVERPAYMENT

1. TOTAL AMOUNT RECOVERED (grant adjustments plus voluntary cash recovery) \$

2. TOTAL UNRECOVERED OVERPAYMENT (Section A, Line 1 minus Section D, Line 1) \$

ELIGIBILITY WORKER: _____ DATE: _____

ABCD 830 (1/86)

**FISCAL MANAGEMENT AND CONTROL
FORMS**

Handbook

25-605

25-605 FORMS (Continued)

25-605

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (Continued)

ABCD 831

REPAYMENT RECEIVABLE RECORD		STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES	
NAME	ADDRESS	STATE NUMBER	
AMOUNT OF REPAYMENT DUE	EFFECTIVE DATE OF REPAYMENT	DEMAND NOTICE SENT	
REASON FOR OVERPAYMENT	TERMS OF VOLUNTARY AGREEMENT		
DATE OF VOLUNTARY AGREEMENT TO REIMBURSE	STATUTE OF LIMITATIONS DATE		
JUDGMENT LIENS IN EFFECT	CRIMINAL ACTIONS TAKEN		
Remarks	Date of Receipt	Amounts Repaid	Balance Due
Remarks	Date of Receipt	Amounts Repaid	Balance Due
Remarks	Date of Receipt	Amounts Repaid	Balance Due
Remarks	Date of Receipt	Amounts Repaid	Balance Due
Remarks	Date of Receipt	Amounts Repaid	Balance Due
Remarks	Date of Receipt	Amounts Repaid	Balance Due

ABCD 831 (8/79)

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25-605 FORMS (Continued)

25-605

IX. MISCELLANEOUS FORMS (See Chapter 25-800)

GEN 215

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL WELFARE

**CLAIM FOR REIMBURSEMENT
LOCAL AGENCY SPECIAL PROJECT**

TO: Accounting Bureau
State Department of Social Welfare
744 P Street
Sacramento, California 95814

NAME AND ADDRESS OF CLAIMANT

PROJECT NUMBER	PROJECT NAME	COVERING EXPENDITURES FOR THE PERIOD
		THRU

CLASSIFICATION OF EXPENDITURES	(A) TOTAL PROJECT EXPENDITURES	(B) COSTS NOT REIMBURSABLE FROM PROJECT FUNDS	(C) COSTS REIMBURSABLE FROM PROJECT FUNDS
Salaries and wages			
Employee Benefit Plans			
Travel Expenses			
Supplies, Materials, Communications and Rental of Equipment			
Equipment Purchase			
Rental of Office Space			
Alterations and Improvements			
Services of Other Governmental Agencies			
Others			
TOTAL ALL CLASSES			

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of the project; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive of the Government Code; that the amounts claimed herein are properly chargeable as expenditures for administration of the project as specified in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Social Welfare Board.

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1093, inclusive, of the Government Code; that the expenditures claimed herein have been authorized; and that payments therefor have been made or expenditures otherwise incurred according to law.

SIGNATURE OF WELFARE DIRECTOR OR PROJECT ADMINISTRATOR	DATE	SIGNATURE OF AUDITOR OR CONTROLLER	DATE
--	------	------------------------------------	------

GEN 215 (3/73)

IX. MISCELLANEOUS FORMS (Continued)

Reverse of GEN 215

**CLAIMING INSTRUCTIONS TO LOCAL AGENCIES
FOR COSTS OF SPECIAL PROJECTS
(WELFARE & INSTITUTIONS CODE, SECTIONS 18200-18204 AND 10609)**

In order that the maximum reimbursement available be provided to agencies for costs of special projects, claims for reimbursement of such costs and the reporting of expenditures will be made in the following manner:

All costs related to the project will be reported to SDSW on Form GEN 215, Claim for Reimbursement (in quadruplicate), and will be segregated into the classes as specified on the approved Budget Schedule (Form GEN 188B) form. Separate claims will be made for each project and project year. Expenditures are defined as follows:

Salaries and Wages: Salary costs for employees' time spent on the special project.

Employee Benefit Plans: The agency's share of cost of employee benefit plans paid for employees spending time on the project. Include costs for such plans as workmen's compensation insurance, unemployment insurance, health and hospital insurance, old age and survivors insurance and other retirement plans.

Travel Expense: Include agency costs for transportation, meals, lodging and incidental travel costs incurred in the performance of duties necessary to the project.

Supplies, Materials, Communications and Rental of Equipment: Include costs to the agency for general office supplies, telephones, telegraph, postage, printing, maintenance and repair of equipment; rental of equipment; heat, light, power, water, maintenance and repair of office space; janitorial supplies and services; and any other such items incidental to the operation of the project.

Equipment Purchase: Cost of equipment purchased for use in the project (including purchases on a rental purchase contract.)

Rental of Office Space: Rental cost of space occupied in the operation of the project.

Alterations and Improvements: Include costs of alterations or repairs of an extensive nature involving substantial structural changes or replacements necessary for the proper and efficient administration of the project. Do not include normal maintenance or upkeep charges.

Services of Other Governmental Agencies: Whenever a governmental agency operating an authorized project finds it necessary to obtain services from other governmental agencies to complete operations of the project for which the original agency has responsibility, the cost of such services are recognized as project costs. In such cases, costs must be determined through the counties' approved A-87 plan.

Others: Include any costs identifiable to the operation of the project which are not included in the above classifications.

Total project costs for the period will be reported in Column A of Form GEN 215.

Project costs not reimbursable from project funds will be reported in Column B.

County Welfare Departments: Project costs not reimbursable from project funds will be included in the regular Administrative Expenditures Claim and will be subject to federal and/or state reimbursement in the same manner as other administrative expenditures of county welfare departments.

Project costs reimbursable from project funds will be reported in Column C. The amounts in Column C are equal to Column A minus Column B.

Records identifying costs claimed shall be maintained on file in the county until notification of completion of audits for the applicable period is received from the State Department of Social Welfare.

IX. MISCELLANEOUS FORMS (Continued)

Suggested Form H

Suggested Form H

Substitute Payee Certification

_____ (Program)

I certify, under the penalty of perjury, that the _____ payment
received on behalf of _____
(name) (case number)

has been spent in behalf of the above named recipient; that such expendi-
tures whenever possible were made after discussion with said recipient;
that due consideration was given to the recipients' rights before making
such expenditures; that the recipients' rights were not abridged; and
that the following is a true and accurate account of the assistance
received:

Month of _____ 19__

Balance from last month	\$ _____
Received this month	_____
Expenditures this month	_____
Remainder at end of the month . . .	_____

Name of substitute payee Date

Address

25-605 FORMS (Continued)

25-605

IX. MISCELLANEOUS FORMS (Continued)

GEN 127

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY		DEPARTMENT OF BENEFIT PAYMENTS	
NOTICE OF FORM CHANGE			
			DATE
TO: County Welfare Department Attn: Supply Clerk		FROM: Forms Management Unit (916) 445-1780	
<input type="checkbox"/> Other			
Listed below is information regarding a form change. Only applicable information is shown.			
It is suggested that this notice be placed in your Department of Benefit Payments Forms Catalog as a reference of form changes.			
FORM NUMBER AND TITLE			
ORDER UNIT	<input type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM	REPLACES	<input type="checkbox"/> Obsolete
QUANTITIES PERMITTED <input type="checkbox"/> Yes <input type="checkbox"/> No		RRP PROVISION REQUIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED Department of Benefit Payments Warehouse 6150 - 27th Street Sacramento, California 95822			
FORMS DISPOSITION AND SPECIAL INSTRUCTIONS			
DISPOSITION OF OLD SUPPLY <input type="checkbox"/> Use until exhausted		<input type="checkbox"/> Destroy	
USE NEW FORM <input type="checkbox"/> When supply available		<input type="checkbox"/> When effective:	
USE FORM IN ACCORDANCE WITH <input type="checkbox"/> Manual Letter No.		<input type="checkbox"/> All County Letter No.	
<input type="checkbox"/> Manual Section(s)		<input type="checkbox"/> Other	
ADDITIONAL INFORMATION			
GEN 127 (7/76)			

**FISCAL MANAGEMENT AND CONTROL
AID CLAIMS**

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**FISCAL MANAGEMENT AND CONTROL
AID CLAIMS**

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25-700	AID CLAIMS - GENERAL	25-700
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This chapter relates to fiscal information on claims; manner of listing this information; forms used in claiming; rules for providing certain types of data and special instructions for compiling and submitting claims.

.1 Purpose and Functions of Aid Claims

The primary function of the aid claim is to (1) provide a record of public assistance expenditures, (2) establish the amount of reimbursement due from the state for federal and state shares of such expenditures made by the counties, (3) substantiate this amount by providing certain financial data and computations, and (4) provide information in a manner easily accessible to audit.

A secondary function is to provide certain statistical data.

25-710	EXPENDITURE REIMBURSEMENT TO COUNTIES	25-710
---------------	--	---------------

Upon approval of the aid claim by the State Department of Social Services (SDSS), county expenditures are reimbursed or advances are adjusted for aid payments made as follows:

- .1 Expenditures incurred from county funds (Cash Claims), or
- .2 Expenditures incurred from federal and state funds previously advanced (Voucher claims).

25-720	TYPES OF CLAIMS	25-720
---------------	------------------------	---------------

Claims are filed monthly with SDSS and are classified as follows:

.1 Cash Claims

Cash claims are for expenditures that are paid on an after-the-fact or arrears basis to the county. Cash claims are normally for items that, on a statewide basis, are not significant in dollar volume or for which there is no authorization for the state to advance funds for the particular expenditure.

.2 Voucher Claims (Advanced Funds)

Voucher claims are applied as credits against advances made to counties. The estimated amount of federal and state funds needed are advanced to the county so that areas of major expenditures will not be initially borne by the county. These advances are deposited to a trust fund in the county treasury, and the county is accountable for these funds until they are legally expended.

25-720 TYPES OF CLAIMS (Continued)

25-720

.3 Types of Aid Claims and Governmental Participation by Program

Program	Federal Funds	State Funds
AFDC-FG&U	Advanced	Advanced
AFDC-FC/Federal	Advanced	Advanced
AFDC-FC/Nonfederal	None Advanced	
AAP/Federal	Cash	Cash
AAP/Nonfederal	None	Cash
Adoption Cost of Care	None	Cash
RCA (Includes ECA)	Advanced	None
RDP	Cash	None
Time Eligible Refugee/ Entrants on GA	Cash	None
Special Circumstance	None	Cash
Time Eligible Refugees on AFDC-FG&U, FC	Cash	None
Emergency Loan (Close-out)	None	1/
Adult (Close-out)	1/	1/
Emergency Assistance - Unemployed Parent Foster Care Time Eligible Refugees 2/	2/	

- 1/ There are no longer claimable costs on these programs. The only activity is repayments collected and reported by counties.
- 2/ Current month expenditures for October 1, 1990 forward may not be claimed, unless the amounts are for prior month supplemental payments or are cancellations. The normal 18 month claiming limit applies to EA expenditures made prior to October 1, 1990 and are to be claimed as prior month adjustments. Repayments must be reported indefinitely.

25-730 FORMS USED IN AID CLAIMS

25-730

Claims for aid payments are prepared on the following forms:

.1 Reports of Expenditures

The summary Report for each program brings together totals of the various payroll, contra rolls and adjustment schedules and provides for computation of federal, state and county sharing, as applicable. For the AFDC-FG&U and AFDC-FC Programs, an additional form is required to claim additional federal funds for time-eligible refugee/entrants to be submitted with the Summary Report. For the RC Program a third form, Facility Expenditures Statement, is attached to the applicable Summary Report to identify certain segments of cost which are not reimbursable from federal and/or state funds. In the following listing these forms are listed under the Summary Report for the pertinent program.

25-730	FORMS USED IN AID CLAIMS (Continued)	25-730
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The following forms are required:

<u>Form</u>	<u>Program</u>
<u>Submitted Monthly:</u>	
CA 800	Summary Report of Assistance Expenditures Aid to Families with Dependent Children.
DFA 844	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee and Entrant Recipients in Receipt of AFDC.
	Note: Separate Reports for AFDC-Family Group and AFDC-Unemployed are required.
CA 800 RDP	Summary Report of Assistance Expenditures Refugee Demonstration Project (RDP)
DFA 844 RDP	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Demonstration Project Recipients (RDP).
	Note: Separate Reports for RDP-Family Group and RDP-Unemployed are required.
CA 800 FC(Fed)	Summary Report of Assistance Expenditures Federal Children in Foster Care.
DFA 847	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement, Cuban Program Phasedown and Cuban/Haitian Entrant Recipients in Receipt of Federal AFDC-FC.
CA 800 FC.1(Fed)	Foster Care Facility Expenditures Statement Amounts not Reimbursable from Federal Funds. (To be attached to CA 800 FC(Fed))
CA 800 FC.2(Fed)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from State Funds. (To be attached to CA 800 FC(Fed))
CA 800A FC(Nonfed)	Summary Report of Assistance Expenditures Nonfederal Children in Foster Care.

25-730 FORMS USED IN AID CLAIMS (Continued)**25-730**FormProgram

DFA 843

Federal Funds Claimable Based on the Expenditures for Refugee Resettlement, Cuban/Haitian Entrant Recipients in Receipt of Nonfederal AFDC-FC.

SOC 801

Summary Report of Assistance Expenditures Emergency Assistance-Unemployed Parent

Note: No new costs subsequent to September 30, 1990 maybe claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.

DFA 863

Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement and Cuban/Haitian Recipients in Receipt of Emergency Assistance-Unemployed Parent.

Note: No new costs subsequent to September 30, 1990 maybe claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.

SOC 800

Summary Report of Assistance Expenditures Emergency Assistance-Foster Care

Note: No new costs subsequent to September 30, 1990 maybe claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.

DFA 863A

Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement and Cuban/Haitian Recipients in Receipt of Emergency Assistance-Foster Care.

Note: No new costs subsequent to September 30, 1990 maybe claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

<u>Form</u>	<u>Program</u>
CA 800 FC.1(Fed)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from Federal Funds. (To be attached to CA 800 FC(Fed))
CA 800 FC.2(Fed)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from State Funds. (To be attached to CA 800 FC(Fed))

Note: This is the same form used for the Federal FC Program.

AD 800A	Summary Report of Assistance Expenditures Adoption Assistance Program/Federal
AD 800B	Summary Report of Assistance Expenditures Adoption Assistance Program/Nonfederal (Includes Aid for the Adoption of Children - AAC)
DFA 846	Summary Report of Assistance Expenditures Refugee Cash Assistance Program (RCA) (Includes Entrants)
DFA 859	Federal Funds Claimable Based on Expenditures for Time Eligible Refugees and Entrants in Receipt of General Assistance.
SC 800	Summary Report of Special Circumstances

Submitted Quarterly:

AD 800	Certification - Adoption Cost of Care Subvention under Welfare and Institutions Code (W&IC) Section 16106.
EL 800	Summary Report of Uncollected Loans.
DFA 837	Summary Report of Assistance Expenditures Old Age Security, Aid to the Blind and Aid to the Disabled.

The Summary Reports provide for the certification of county officials. The certification shall be accomplished by the affixing of the personal signatures of the county welfare director and the county auditor or representatives of these officers who are properly authorized. If the certification is accomplished by an authorized representative, the representative signs his own name and uses his own title.

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25-730 FORMS USED IN AID CLAIMS (Continued)**25-730****.2 Reconciliation Statement, Form ABCD 820**

The Reconciliation Statement is prepared from batch voucher controls as provided in MPP Handbook Section 25-230.3. It demonstrates on a total basis that each aid claim includes only amounts authorized to be paid. Adequate records are to be maintained in the county to support the figures included in the statement.

Only amounts authorized to be paid or warrants to be canceled and the persons counts included in these authorizations shall be included in Items 1 through 10 of the statement. If there is a difference between the amounts in Items 10 and 11, or between the persons count in Items 10 and 12, this difference shall be stated in Items 13 and/or 14 and shall be explained adequately either below Item 14 or on a separate sheet.

Proper procedure requires that the reconciliation control total be maintained and verified currently as authorizations are approved, resulting in predetermined totals controlling the amounts of aid to be paid and claimed each month. This procedure enables detection of under or overpayments before warrants are released. It also serves as a signal that there are errors in the aid claims which should be located and corrected, if possible, prior to transmittal of the claim to SDSS.

Those counties operating on the case data processing system are not required to submit a Reconciliation Statement.

.3 Aid Payrolls (Contra Rolls)

.31 The Form ABCD 801 is used to report payments, cancellations, abatements, adjustments, zero grants and repayments for the AFDC-FG&U, AFDC-FC, AAP, RCA, Time Eligible Refugee/Entrants on GA, Special Circumstances and repayments on the Adult Close-Out Claim.

.32 The Form AD 801A is used as a payroll (contra roll) for the Adoption Cost of Care Program. (See MPP Handbook Section 25-755.)

The original of these forms is required by SDSS. Copies retained by the county shall be exact duplicates.

The information required on SDSS prescribed payroll and contra roll forms is the minimum information required. Any special county forms shall contain all of the information required by the state forms in the same sequence. Any county substitute for the prescribed forms shall not be used by the county prior to specific written approval by Fiscal Policy and Procedure Bureau, SDSS.

25-730 FORMS USED IN AID CLAIMS (Continued)**25-730****.4 Integrated Payrolls**

The Integrated Payroll is a listing of payroll and contra roll information in case number sequence with a net total, by case, by current month and prior months, of persons count and total aid paid. When the information on all of the payrolls and contra rolls for a program is merged and one listing is prepared, the term Fully Integrated Payroll is used to describe the listing.

Fully integrated payrolls are required for those counties having data processing equipment. Counties submitting separate integrated payrolls for FG and U are requested to combine these two categories in one fully integrated payroll.

.41 The following payroll and contra roll codes, if used on the Integrated Payroll for identification and accumulation purposes, may be used without definition of the codes on the payroll:

Main Payroll	1
Current Month Supplemental Payroll	2
Current Month Cancellation Contra Roll	3
Zero Grant	4
Prior Month Supplemental Payroll	5
Prior Month Cancellation Contra Roll	7
Abatements	8
Schedule of Adjustments	9
Repayments	10

.5 Integrated Payroll Summary

The Integrated Payroll Summary is an accumulation of totals by payroll and contra roll code and is required to support the totals carried forward to the Summary Reports.

Counties submitting a fully integrated AFDC payroll will prepare two separate integrated payroll summaries accumulating totals by aid program 30 for AFDC-FG cases and aid program 35 for AFDC-U cases. An integrated payroll summary combining FG and U totals is not necessary for SDSS.

.6 Integrated Payrolls and Payroll Summaries for Time Eligible Refugee/Entrants

When time eligible refugees/entrants are claimed on the AFDC-FG&U or AFDC-FC Programs, the following procedures apply:

25-730	FORMS USED IN AID CLAIMS (Continued)	25-730
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.61 AFDC-FG&U Federal and Nonfederal Programs

All cases which include at least one time eligible refugee/entrant will be coded 30, 32, 33, or 35 as determined by the program for which they are eligible. Transactions for these cases must be claimed on a payroll separate from transactions for all other cases on that program. Each segment of the program must be combined and carried forward to the appropriate Summary Report. The separate payroll will be used to substantiate the additional federal funds claimed for time eligible refugees/entrants. (See MPP Handbook Sections 25-730.1.) On the Time Eligible Refugee/Entrant Payroll, the Date of Entry (DOE) must be shown for each time eligible refugee and the Date of Parole (DOP) shown for each time eligible entrant. (For instructions for Refugee Demonstration Project (RDP) see MPP Handbook Section 25-756.)

.62 AFDC-FC Federal and Nonfederal Programs

All cases which are time eligible refugee/entrant cases will be coded 40 or 42 as determined by the program for which they are eligible. The requirements for separate payrolls and DOE and DOP as specified in MPP Handbook Section 25-730.61 for the AFDC-FG and U Programs are applicable to the AFDC-FC Federal and Nonfederal Programs.

EXCEPTION: For those counties whose claiming system (computer or manual) cannot supply the DOE/DOP on the Time Eligible Payrolls, a separate listing per program providing the dates will be acceptable. For those counties whose computer system requires that time eligible cases remain intermingled with all other cases on the program, a select run of the time eligible cases with an accompanying Integrated Payroll Summary is acceptable.

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25-740 TYPE OF PAYROLLS AND CONTRA ROLLS**25-740**

The payrolls and contra rolls are reports of payments made, warrants canceled, abatements received, adjustments processed, and repayments received during the months.

EXCEPTION: When a services plan to resolve money management problems includes use of vendor payments (AFDC only), and a trust fund method as provided by MPP Handbook Section 25-362 is used, the total aid authorized is claimed in the month of payment to the trust fund regardless of the date the payments are made from the trust fund.

NOTE: References below to alternate pay period are applicable in only those counties having an approved alternate payment system. (See MPP Section 44-305.3.)

.1 Main Payroll (Master Payroll Payments)

These are payments of the continuing aid grant.

Totals are included as gross expenditures on the Summary Report of Assistance Expenditures, Line 1.

.2 Current Month Supplemental Payroll

These are payments for the current month or current alternate pay period made after the master payroll for the month it is prepared. Included are initial payments, reissuances of warrants canceled and increases.

Depending on the reason for the supplemental payments, persons counts mayor may not need to be reported in the persons count columns.

Totals are included as gross expenditures on the Summary Report of Assistance Expenditures, Line 2.

.3 Current Month Cancellation Contra Roll

Current cancellations are warrants canceled in the current month which were issued during the current month for either the current month or some prior month(s) or for the current or prior alternate pay period.

Persons count as reported when the warrant was claimed must be canceled with the cancellation of the warrant except in the following circumstances:

.31 When the warrant is canceled and a warrant is issued in lieu in the same month and the same persons count applies, or

.32 When a warrant (main or supplemental, with which persons count was reported) is canceled and a supplemental warrant for the same month or alternate pay period remains in effect, or

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued)**25-740**

- .33 In AFDC when only the first warrant is canceled and the same persons count extends to the second warrant.

Totals are included as reduction of gross expenditures on the Summary Report of Assistance Expenditures, Line 3.

.4 Zero Grants

There are currently three types of zero grant cases. Persons counts for two types of zero grant cases are claimed on Line 4 of the Summary Report (thus impacting the federal financial participation ratio) and persons counts for the third type of zero grant cases are not claimed on the Summary Report and, therefore, do not impact the federal financial participation ratio. All three types of zero grant cases are claimed as Code 4 on computer printed payrolls. On manually prepared payrolls, separate listings for each type of zero grant case are required. (For further general information, see MPP Handbook Section 25-740.44 below.)

Adjustments for persons previously omitted or erroneously reported are made on the zero grant list or zero grant code, not on the Schedule of Adjustment or the adjustment code.

.41 Zero Grant-Overpayment Adjustment

These AFDC-FG&U cases are eligible for a cash grant for the current month or current alternate pay period because the net nonexempt income does not exceed the Maximum Aid Payment (MAP) available for the number of persons included in the AU. However, the grant for the current month or alternate pay period has been reduced to zero to adjust for a prior overpayment.

This is in lieu of discontinuance followed by a restoration action, in order to retain eligibility status for medical assistance, and to simplify authorization procedures. The federal and nonfederal persons counts are carried forward to Line 4 of the Summary Report, thus impacting the federal participation ratio.

.42 Zero Grant - Payment Less than \$10

These AFDC-FG&U cases are eligible for a cash grant because the MAP for the AU is greater than net nonexempt income, but because the difference is less than \$10, no payment is made for the month or the alternate pay period. Such cases shall be considered to have received payment for all other purposes, including payment of special needs. Persons counts for the cases are claimed on Line 4 of the Summary Report; there, do impact the federal financial participation ratio.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued)**25-740**

In those instances where the AU was eligible to a grant in excess of \$10 but an overpayment adjustment decreased the amount of the payment to less than \$10, a payment is made in the amount less than \$10.

.43 Zero Basic Grant

These cases are eligible for payment of special need but not basic need because the net nonexempt income is equal to, or exceeds, the MAP available but does not exceed the Minimum Basic Standard of Adequate Care (MBSAC) based on the size of the AU. For any month or alternate pay period for which no special need payment is made, persons count is shown on the payroll but identified as NG (Nongrant).

The persons counts are not carried forward to the Summary Report and, therefore, do not impact the federal financial participation ratio.

.44 Aid Suspended for One Month

This type of case is not classified as a zero grant but is addressed here because of similarity.

A case is suspended, rather than terminated, when income or other circumstances in the corresponding budget month appear to result in ineligibility for only one month. The case is automatically restored to aid payment status the following month. No money payment nor persons counts are claimed for such cases on the payroll. It is preferred that the case identification number and case name not be shown on the payroll. If the county decides, based upon their system's capabilities, that it is not feasible to remove the case record from the master file for only one month, then such case is coded "S" on the payroll.

.5 Prior Month Supplemental Payroll

These are payments for a prior month(s) or a prior alternate pay period(s) made during the current month.

Payments for prior months or for prior alternate pay periods will be grouped on the payroll according to month or period in state number order under each month or period.

If one warrant is issued covering more than one prior month or prior alternate pay period for a given case, the total warrant amount need not be shown, but the amount paid for each individual month or prior alternate pay period shall be reported separately.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued)**25-740**

Depending on the reasons for the supplemental payment, persons counts may or may not need to be reported in the persons count columns.

Totals are included as gross expenditures on the Summary Report of Assistance Expenditures, Line 5.

.7 Prior Months Cancellation Contra Roll

Prior cancellations are warrants canceled in the current month which were issued and claimed in some prior month.

Prior cancellations are reported by grant month or alternate pay period in state number order on contra rolls as originally reported. If the originally reported persons count, and/or amount of aid have been changed by abatement or adjustment, the cancellation of the warrant may necessitate a reversing adjustment, applying the abatement to another month or another alternate pay period, or possible return of the abatement.

If the cancellation of the warrant with persons count does not cancel the total aid paid for the month or alternate pay period, an adjustment to add persons count may be necessary.

Totals are included as a reduction of gross expenditures on the Summary Report of Assistance Expenditures, Line 7.

.8 Abatements

An abatement is any cash payment (other than child support) received from or in behalf of any individual or family during a month or alternate pay period that the individual or family is in receipt of aid. For abatement reporting purposes, an individual is considered in receipt of assistance if the grant has been reduced to zero because of a previous overpayment, or if there has been no payment of assistance because the amount the AU would receive is less than \$10.

Types of abatements include:

- (a) Current income (i.e., monthly Social Security (SS) or veteran's benefits normally payable in the month of receipt when made payable to the welfare department and deposited to the welfare fund).
- (b) Current cash adjustment (collection of an overpayment in lieu of a grant adjustment).
- (c) A voluntary contribution made by a relative having no legal obligation to contribute.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued)**25-740**

- (d) Recovery of interim assistance payments made in behalf of a nonfederal FC child determined eligible for Supplemental Security Income/State Supplemental Program (SSI/SSP).

When the requirements of MPP Section 46-337 are met, interim assistance payments made in behalf of a nonfederal FC child determined eligible for SSI/SSP are deducted from the initial SSI/SSP payment received by the county. It is necessary that the amount of FC funds recovered be reported as an abatement on a current AFDC-FC claim.

Abatements applicable to two or more months or two or more alternate pay periods will be broken down and reported by amount for each month or alternate pay period.

When the full amount claimed for any month or alternate pay period is entirely abated, enter the persons count in the appropriate column. In AFDC, if there was an overpayment because one or more of the family group was ineligible to aid, a persons count is reported (unless previously corrected) although the abatement covers only that portion of the total aid overpaid.

Column 11 of the ABCD 801 shall be used to report either the deposit permit number or receipt number. Counties preparing integrated payrolls shall report the required number in the "Warrant Number" column of the payroll.

The date of receipt by the County Welfare Department (CWD) shall be reported in Column 12 of the ABCD 801 or in the "Issue Date" column of the integrated payroll.

Totals are included as a reduction of gross expenditures on the Summary Report of Assistance Expenditures, Line 8.

.81 Erroneous Abatements

Amounts collected from recipients of aid on an erroneous assumption that an overpayment occurred, or an amount collected in excess of the amount receivable, are reported as follows:

- .811 If an abatement later determined to be erroneous has already been reported on a claim, and such abatement is returned, the county shall report the return on a current claim. It is reported as:
- (a) A supplemental payment for a prior month(s), or
 - (b) A debit item on the Abatement Contra Roll.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued)

25-740

- .812 When a persons count has been deducted when reporting an abatement later determined to be erroneous, the return of the abatement restores the persons count and the count is reported as originally claimed. The rule regarding federal participation in retroactive payments does not apply since the return of an erroneous abatement is an adjustment.

.9 Schedule of Adjustments

Claim adjustments are reported on the Schedule of Adjustments and usually result from discovery that claiming error has been made affecting amount claimed, participation status, and/or persons count. Adjustment may increase or decrease the amount claimable.

EXCEPTION: Adjustment of zero grants, abatements and repayments are made on the respective rolls or payroll codes rather than on the Schedule of Adjustments or adjustment payroll code.

Specific authorizing action for the adjustment may or may not be necessary depending on the reason for the adjustment.

- .91 To correct an item authorized correctly but claimed incorrectly, no additional authorizing action is necessary. The county must develop some system to get such adjustment data from the point of discovery to the Schedule of Adjustments.
- .92 To change an item authorized correctly and claimed correctly, but on which subsequent information indicates need for change in such authorization, additional authorizing action is necessary and the county's normal Forms 278L-M procedures (or other approved procedures) apply.

Claim adjustments include (but are not limited to) the following types of transactions:

- (a) Correction of an item reported incorrectly on a current or prior claim (e.g., amount claimed in excess of warrant amount issued);
- (b) Change in financial participation (e.g., federal to nonfederal);
- (c) Addition of an item omitted in error (e.g., person added to the AU and grant increased accordingly; additional persons count not claimed);
- (d) Deletion of persons count and total of aid paid when county began aid prior to the date specified in MPP Section 44-317.

25-740 **TYPE OF PAYROLLS AND CONTRA ROLLS (Continued)** **25-740**

- (e) Deletion of an unauthorized payment claimed and any persons count claimed with the unauthorized payment.
- (f) Deletion of persons counts erroneously claimed when the amount claimed as authorized is not affected.
- (g) Repealed by Manual Letter No. FMC-90-04, effective 12/1/90.

In reporting the item to be corrected, the net increase and/or decrease of persons count and total aid paid is reported in a single line entry.

The totals (persons counts and total aid paid) are included on the Summary Report of Assistance Expenditures, Line 9.

.10 Repayments

A repayment is the recouping of assistance from or in behalf of a former recipient of assistance. This may be recovery of an overpayment or a voluntary repayment or contribution when there is no legal obligation to repay.

Repayments may be integrated or reported on a separate Repayment Contra Roll. Report only the case number, name, amount and receipt number. The receipt number may be placed in the "Warrant Number" column. The month and year are left blank. No persons counts are involved since the single percentage takes in all factors of federal, state and county sharing.

.101 Erroneous Repayments

Amounts collected from recipients on an erroneous assumption that an overpayment occurred, or amounts collected in excess of the amount receivable are reported as debit items on the Repayment Contra Roll or on the repayment code when returned.

Adjustment of repayment items are made on the Repayment Contra Roll or on the repayment payroll code, not on the Schedule of Adjustments or the adjustment code.

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25-750 REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS 25-750

County payments of aid shall be listed in state case number order on aid payrolls unless otherwise provided in this chapter. On the FC payrolls, cases may be listed alphabetically by payee. If the alphabetical arrangements are used and there is more than one case with the same payee, they shall be listed in state case number order under the name of each payee.

Allow double space between line items.

EXCEPTION: On integrated payrolls, single space the information for each case and triple space between cases.

All pages in a payroll or contra roll shall be numbered consecutively and shall carry individual totals by page for persons count and warrant amount columns. Page totals shall be added and the grand totals inserted on the last page of each payroll or contra roll.

Page totals are not required on integrated payrolls, but grand totals of persons count and total aid paid columns are required.

NOTE: Special instructions for specific programs are to be found in other sections of this chapter.

On all payrolls and contra rolls, the following information shall be provided in the appropriate headings and columns:

- .1 The Name of the County Filing the Claim
- .2 The Month and Year of the Claim
- .3 The Type of Payroll or Contra Roll (see Section 25-740)
- .4 State Case Number or Other Required Identification Number
- .5 Payee Name

- .51 All Programs

In all programs, show the payee name as it appears on the authorization document. If the county mechanical equipment makes it advisable, the given initial only need be shown. The name of each child and the amount for each child in an AU need not be separately reported. See .52 below for exceptions.

- .52 Payee Codes

25-750 **REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS** **25-750**
 (Continued)

.521 If a guardian or conservator has been appointed, show the name of the payee and note on the payroll that the payee is other than the recipient. Suggested codes:

(a) If the GUARDIAN is the payee GN

(b) If the CONSERVATOR is the payee CN

.522 When the services plan to resolve money management problems includes use of a protective payment or vendor payments, show the name of the payee and note on the payroll that the payee is other than the recipient. Suggested codes:

(a) If a SUBSTITUTE PAYEE is the payee SP

(b) If a VENDOR PAYMENT is made directly to an individual or agency supplying goods or services to the family VP

NOTE: See MPP Handbook Section 25-360.

.6 Payment Codes on Payrolls

The following must be identified on payrolls. If the suggested codes are used, no definition of the codes is needed on the payroll. These codes may be substituted by county codes upon approval by SDSS if the county's payroll defines the codes used.

(a) Immediate Need Payments EA

(b)* Payments containing an amount for Special Needs (AFDC, RCA, ECA) SN

(c) Warrants reissued after voiding because of being outstanding over six months from the date issued VR

(d) An AFDC case (federal and/or nonfederal) RDP or GA case which includes one or more time eligible refugees IR/OR

NOTE: It is no longer necessary, for fiscal purposes, to identify time eligible refugees from Cambodia, Laos and Vietnam from all other time eligible refugees.

*When applicable, identify cancellations, abatements and adjustments as well as payments (including supplemental).

25-750 REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS 25-750
(Continued)

- | | | |
|-----|---|----|
| (e) | An AFDC case (federal and/or nonfederal) RDP or GA case which includes one or more time eligible entrants | CH |
| (f) | Time eligible refugee/entrant children in receipt of FC (federal or nonfederal) | FC |
| (g) | Unaccompanied refugee entrant minors in receipt of RCA | UM |
| (h) | Unaccompanied refugee entrant minors in receipt of ECA | EM |
| (i) | Expenditures for burial expense made for time eligible refugees/entrants on AFDC-FG&U, FC, RDP, RCA and ECA | BE |
| (j) | Adoption Assistance Program cases - Nonfederal | N |

NOTE: These are cases which became eligible on or after October 1, 1982. This coding is not to be used for the old AAC cases which are also identified with the 04 aid code.

- | | | |
|-----|--|----|
| (k) | Adoption Assistance Program payments in excess of the Foster Family Home Rate | A |
| (l) | AFDC-FG&U case suspended for only one payment month because of income or other circumstances in the budget month | S |
| (m) | Foster Care payments made to Home Finding Agencies | HF |
| (n) | Foster Care payments which include a clothing allowance | CE |
| (o) | Foster Care payments which include Social Worker Activity and/or Nonfederal Other amounts | E |
| (p) | Special Circumstances | |

Each payment made for Special Circumstances shall be coded by the type of Special Circumstance granted. These codes are as follows:

FE Furniture and Equipment

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25-750 **REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS** **25-750**
(Continued)

- FC Clothing
- ME Necessary Moving Expenses
- HR Required Housing Repairs
- US Unmet Shelter Needs
- HM Home Modification
- PF Payment to Prevent Foreclosure

.7 The Grant Month

.8 The Persons Counts

The Persons Counts for individuals eligible to aid segregated as to federal adults, federal children, nonfederal adults, and nonfederal children. In AFDC, FG and U, the persons count is reported with the first warrant for the month and when applicable, with supplemental warrants.

NOTE: As it is no longer necessary to capture essential persons count on the claim in a separate column, the persons count for an essential person is claimed as a federal persons count.

.9 The Warrant Amount

In AFDC, FG and U, include special need in the warrant amount when applicable. The first and second warrants are listed together on the payroll in date sequence and totaled (except on payrolls prepared by addressograph or typewriters).

.10 The Warrant Number

.11 The Warrant Date

The Warrant Date is placed in Column 12 of the ABCD 801; however, if all warrant numbers on a given roll or page carry the same date, the date may be indicated at the beginning of the roll or top of the page rather than individually for each warrant.

.12 The Authorization Date

The Authorization Date, which may be used as an additional control, is also placed in Column 12 of the ABCD 801. On the Zero Grant List include only Items .1 through .4 above, the payee name, the Nongrant payment code, when applicable, and Items 7 and 8. (See MPP Handbook Section 25-740.4.)

25-752 SPECIAL CIRCUMSTANCES CLAIMING INSTRUCTIONS**25-752**

This program provides for payments for expenditures incurred by SSP recipients for special circumstances as defined in MPP Section 46-400. Special circumstances payments are claimed monthly on the Summary Report, Form FC800.

Nonintegrated payrolls and contra rolls should be separated into three sets according to expenditures made for aged, blind, and disabled recipients. For those counties submitting an integrated payroll all transactions should be integrated; however, it will necessary to prepare three separate integrated summaries by aged, blind and disabled categories. If a county's computer system will not accommodate preparation of the special circumstances payrolls and contra rolls if aid categories 10, 20 and 60 are used, aid codes 12, 22, and 62 may be used for special circumstances payments.

The payroll will be prepared on Form ABCD 801, or equivalent form, and in Social Security Number (SSN) order unless the county's system cannot accommodate the nine-digit SSN. Additional information required includes:

- .1 The recipient's name.
- .2 Coding for type of need provided. (See MPP Handbook Section 25-750(p).)
- .3 Total aid paid.
- .4 Warrant number.

25-753 REIMBURSEMENT FOR FUNERAL COSTS FOR CHILDREN IN FOSTER FAMILY HOME PLACEMENT**25-753**

State funds are available for reimbursement of funeral costs for children who had been placed in foster family homes. (MPP Section 11-405.2 and MPP Handbook Section 25-320(1)). The payment is made to the foster parent(s) or upon request of the foster parent(s), the county shall authorize payment be made to the funeral home and burial plot provider. When death of the foster child is due to the foster parent's alleged criminal negligence or other alleged criminal action, the county shall authorize payments be made to the funeral home and burial plot provider.

If the child had been a federally eligible foster care child, reimbursement is claimed on the Summary Report of Assistance Expenditures - Federal Children in Foster Care, Form CA 800 FC(Fed), Line 20, Columns B and D. If the child had been nonfederally eligible, the costs are claimed on the Summary Report of Assistance Expenditures - Nonfederal Children in Foster Care, Form CA 800 AFC(Nonfed), Line 18, Columns B and C. These costs must be substantiated by a separate payroll (Form ABCD 801 or the county's equivalent form) submitted with the monthly AFDC-FC payrolls. Required information includes the case number for the child, the payee name, the warrant amount, the warrant number and warrant date.

25-754 ADOPTION ASSISTANCE PROGRAM CLAIMING INSTRUCTIONS 25-754

Payments made for a child who has been determined to be federally eligible for the AAP in accordance with MPP Section 45-802.12 shall be claimed on the Summary Report of Assistance Expenditures - AAP/Federal, Form AB 800A. Provision is made in Lines 13A and 14A of the Summary Report to allow federal participation in only that rate which would be available if the child were in a family foster home. State participation shall supplement the remainder of the payment.

Payments for adoption cases which do not meet the AAP federal eligibility standards are claimed on the Summary Report of Assistance Expenditures-AAP/Nonfederal (includes Aid for the Adoption of Children - AAC) Form AD 800 B. (See MPP Handbook Section 25-525.)

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25-755 CLAIMS FOR ADOPTION COST OF CARE**25-755**

Reimbursement from state funds is available to each county, including licensed county adoption agencies, for the full cost of care of any child placed under the custody of the CWD pursuant to Section 226c of the Civil Code, from the effective date of the court commitment until the date of placement for adoption, or until another permanent plan is made for the child.

.1 Claimable Costs

Cost of care is defined as the cost to the county of goods, facilities, and services incurred to meet the needs of children placed under the custody of the CWD, including housing, food, clothing, medical, dental, nursing or psychiatric services, and other personal needs. Claimable costs do not include expenditures incurred prior to the date of the court commitment to the SDSS or county adoption agency under Section 226c of the Civil Code, nor expenditures incurred subsequent to placement for adoption, nor after another permanent plan is made for the child by SDSS or county adoption agency. Expenditures incurred, but not disbursed, cannot be allowed.

If the child is not eligible for the AFDC-FC Program, the payment to the provider shall be claimed directly on the Adoption Cost of Care Claim. If the child is eligible for AFDC-FC, payment for such child shall be made through the AFDC-FC Program in the same manner as any other foster care provider payment. The AFDC-FC claiming mechanism provides the normal federal, state and county participation in the aid payment. That part of the payment which is determined as county share (any amount not reimbursed by federal or state funds) must then be claimed in Column 5 of the Form AD801A (Claim-Adoption Cost of Care under Welfare and Institutions Code Section 16106) and summarized on the Form AD800 (Certification-Adoption Cost of Care Subvention). All other applicable information on both forms must be completed as instructed on the forms.

The adoption cost of care claim shall include all children for whom care was given during the months in the calendar quarter covered by the claim.

EXCEPTION: If payment for cost of care is made in a quarter subsequent to that in which the care was given, the date of disbursement governs the quarter for which the claim is filed.

25-756 REFUGEE DEMONSTRATION PROJECT (RDP)**25-756**

Effective July 1, 1985 a three-year statewide Refugee Demonstration Project(RDP) was implemented in California. All counties in which there are SDSS funded or Targeted Assistance refugee employment/training programs must participate in the RDP. (See MPP Section 69-200.)

Effective July 1, 1985 refugee cases which were currently aided on AFDC-FG/U and in which the relative caretaker or the principal earner had at least 12 months of time eligibility remaining were required to participate in the RDP. The county welfare departments (CWDs) were required to transfer these cases from the AFDC-FG/U Program to the RDP Program. The transfer period was designated as July1, 1985 through September 30, 1985 with instructions that one-third of the caseload should be transferred per month.

Effective July 1, 1985 all refugee applicant cases which would otherwise be aided on the AFDC-FG/U Program and in which the relative caretaker or the principal earner has at least six months of the time eligibility remaining are also required to participate in the RDP and must, therefore, be aided in the RDP.

When the relative caretaker or the principal earner time expires (36 months after date of entry) the AU must be discontinued from RDP. A determination must be made if the AU is eligible for another aid program.

The claimant of RDP expenditures must be separately identified from AFDC-FG/U expenditures. Each RDP reporting system (FG/U) must provide separate payrolls. Separate summaries of the integrated payroll are required for those counties submitting an integrated computer payroll; i.e., one for the FG component and one for the U component. Aid Codes 77 (RDP-FG) and 78 (RDP-U) are used for identifying cases aided under the RDP. The expenditures for the separate components are claimed on separate Forms CA 800 RDP, Summary Report of Assistance Expenditures, Refugee Demonstration Project (RDP).

Assistance payments for time-eligible persons in RDP cases are 100 percent federally funded. The nonfederal share of assistance payments for time-expired persons in RDP cases is funded at the 89.2/10.8 percent state/county rate.

25-758 CLAIMING INSTRUCTIONS FOR RETROACTIVE BENEFITS**25-758**

The following simplified procedures may be used when claiming retroactive payments made to comply with court judgments (see MPP Division 50).

Retroactive payments may be authorized by a single line entry on the ABCD 278L (or substitute authorizing document) and paid in one warrant. The months covered in the amount authorized will be identified on the authorizing document. The minimum information needed on the Aid Payroll is case number, name, persons county (when applicable), grant amount and warrant number.

A list of court-ordered retroactive assistance payments must be included with the appropriate monthly assistance claim for any month in which such payments are made. The list may be handwritten, typed or computer generated and must be attached to the front of the payroll. The information on the list must include the case name, case number and payment amount of the court-ordered retroactive payment(s). In addition, each payment must be identified as to the pertinent court case.

25-759 REPATRIATE PROGRAM CLAIMING INSTRUCTIONS**25-759**

The Repatriate Program consists of a program for the needy and a program for the mentally ill.

The purpose of the Repatriate Program for the Needy is to help U.S. citizens and their dependents who are certified as eligible by the Department of State, at the point of their return to the U.S. and for a temporary period thereafter, and to enable them to utilize other resources for maintenance as soon as possible. The purpose of the Repatriate Program for the Mentally Ill is to help U.S. citizens/nationals who are certified as eligible by the Department of State at the point of their return to the U.S. and thereafter with necessary assistance, care and treatment for a temporary period and to make arrangements for the transfer of responsibility for such persons for continued care and treatment.

State standards for the program of Aid to Families with Dependent Children (AFDC) shall be used in determining the amount of financial assistance needed by individuals or families. When aid is needed for resettlement or in the place of residence, financial assistance for initial, one-time services may exceed the AFDC standard. (Prior approval should first be obtained through SDSS.)

Form SSA-3955, Expenditure Statement and Claim for Reimbursement shall be used to report and claim expenditures on each repatriate case, unless or until the volume and nature of the cases is such that group reporting is indicated. Claims are to be submitted in quadruplicate as soon as possible after the end of each month but not later than 15 days after the close of the month. A copy of a receipt or bill shall be attached to the SSA-3955 for unusual expenses such as medical bills. County agency records shall contain sufficient information to support the validity of each claim. The completed copies of Form SSA-3955 shall be sent to the SDSS, Disaster Response Services Bureau, MS 19-43, 744 P Street, Sacramento, CA 95814.

Reimbursement for assistance provided by the county agency under the Repatriate Program for the Needy is available for costs identified in MPP 68-104.2.

Reimbursement for assistance provided by the county agency under the Repatriate Program for the Mentally Ill is available for costs identified in MPP 68-106.

Identifiable administrative costs incurred by the county agency in providing assistance to eligible persons under both programs are also reimbursable and are to be claimed in the space designated "Other" on the SSA-3955. An explanation fully describing the administrative costs is to be attached to the SSA-3955.

25-760 ASSEMBLING OF CLAIMS**25-760****.1 Number of Copies Required**

Only the original of each required document and each payroll or portion of a payroll must be submitted.

.2 Method of Compiling Claims**.21 General**

The claim shall be assembled in the following order: a. on top and fastened at the top with an ACCO type fastener:

- (a) Summary Report of Assistance Expenditures
- (b) Reconciliation Statement
- (c) Main Payroll
- (d) Current Month Supplemental Payroll
- (e) Current Month Cancellation Contra Roll
- (f) Zero Grant Lists
- (g) Prior Months Supplemental Payment
- (h) Prior Months Cancellation Contra Roll
- (i) Abatement Contra Roll
- (j) Schedule of Adjustments
- (k) Repayment Contra Roll
- (l) Protective Backing Sheet

NOTE: There are additional required documents for specific claims. As an example, under certain circumstances, some counties must submit a Form Number DFA844 with each Report of Expenditures for AFDC-FG and AFDC-U. This form is utilized to claim the nonfederal share of expenditures for time eligible refugees/entrants. Any such required document(s) should be assembled directly behind the Report of Expenditures.

.22 Exception for AFDC Claims

Counties preparing payrolls on typewriter or addressograph will assemble the FG and U payrolls separately in the order prescribed inc. through k. above and the entire claim will then be assembled as follows:

Summary Report of Assistance Expenditures - FG

Summary Report of Assistance Expenditures - U

Reconciliation Statement(s)

FG Payrolls

U Payrolls

Protective Backing Sheet

25-770 TRANSMITTAL OF CLAIMS**25-770**

All aid claims filed with SDSS shall be forwarded by the counties so as to be received not later than the 8th working day of the month immediately following the month or quarter of claim. The ability of SDSS to prepare quarterly statements of expenditure for the federal government within the required deadline, which is necessary to assure timely monthly advances of federal monies to the counties, depends upon prompt transmittal of county claims.

All claims shall be addressed to SDSS, 744 P Street, Sacramento, California 95814, Attention: Claims Audit and Control, MS 8-300.

Each claim shall be transmitted completely at one time.

Statistical reports and material for other divisions or bureaus of SDSS shall not be packaged with aid claims.

25-775 SUBMISSION OF ASSISTANCE PAYROLLS ON MICROFICHE**25-775**

Those counties which have the capacity and wish to submit assistance payrolls on microfiche in lieu of computer printout for integrated payrolls may do so, provided advance notice is given to the Assistance Fiscal Policy Unit of the Fiscal Policy and Procedures Bureau. Claims submitted on microfiche must be submitted in accordance with the following specifications:

- (a) Reduction: 48 x is preferred; 42 x is acceptable.
- (b) Line per frame: Standard 56 lines; triple spacing should be used between case entries, per MPP Handbook Section 25-750.
- (c) Fiche Sequence:
 - (1) Each program is to begin a new fiche.
 - (2) Each fiche should be numbered consecutively, as specified in the index information.
- (d) Format:
 - (1) All information currently displayed on the printout must be on the microfiche. This includes page totals, end of payroll totals, code key, and statistical reports.
 - (2) Summary Report pages should appear at the end of the payroll.

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(Continued)

- (e) Index System:
- (1) Eye - readable title line across the top of each fiche containing:
 - (A) County number
 - (B) First case number appearing on fiche.
 - (C) Program identifier
 - (D) Month/year of report
 - (E) Fiche number in sequential order for the entire claim
 - (2) The final frame of each fiche should contain an index showing the first case number on each frame. Each number should be cross-referenced to the appropriate frame by use of an alpha-numeric grid index, i.e., A-1, B-1, etc. Each frame would be likewise identified.
- (f) Accessibility to Audit: Microfiche viewers must be made available to state and federal auditors. In addition, the county should have access to a reader-printer in the event that a hard-copy document is required for audit purposes.
- (g) Quality Control: A monitoring process should be developed to assure that the tape which generates the microfiche contains all program input; also that the microfiche produced is legible quality and that it contains all information from the tape.
- (h) Submittal: One microfiche copy should be submitted to SDSS. Follow the instructions contained in MPP Handbook Section 25-770.
- (i) Retention of microfiche records: Follow instructions contained in MPP Handbook Section 25-602.
- (j) Destruction of microfiche records: Follow instructions contained in MPP Handbook Section 25-210.8.