"New" Form

SPONSORED NONCITIZENS APPLYING FOR OR RECEIVING CASH AID AND/OR CALFRESH

Important Information For Noncitizens Sponsored By Individuals

As a noncitizen who is sponsored by an individual(s), you must meet special rules to get Cash Aid and/or CalFresh.

The Special Rules Are:

- Your sponsor's income and resources will have to be reviewed to see if you can get benefits. Your sponsor must fill out the attached form. Both you and your sponsor must sign this form.
- If your application is approved, you and your sponsor will have to report your income and resources every six months to keep getting Cash Aid and CalFresh benefits. If your sponsor does not provide this information, your benefits may be changed or stopped. Family members who are not sponsored and are otherwise eligible can keep getting their benefits.
- **You are the person responsible for getting all the information requested to the county welfare department for both you and your sponsor. Let the county know if you need help.**
- If your sponsor has abandoned you (you don't know where they are or they don't help you out) you might still be able to get benefits.

Important Information For Sponsors

The noncitizen you sponsor has applied for Cash Aid and/or CalFresh. If you signed an affidavit of support, State regulations require the county welfare department to review your income, resources, and property in deciding whether or not the noncitizen applicant can get benefits. Sponsorship is normally for an indefinite period of time. This form must be completed and signed by you under penalty of perjury. If you are living with your spouse or your spouse has signed an affidavit of support, your spouse's income, resources, and property are also counted.

If the noncitizen's application for Cash Aid is approved, **each semi-annual period (every six months)** you will have to report your income, resources, and property on either this form or on the Sponsor's Semi-Annual Income and Resources Report (SAR 72). The noncitizen will give you the report form. Your report must be completed and returned to the noncitizen immediately to ensure the noncitizen's continued eligibility. Each semi-annual period, resources and a portion of your income will be used to determine the noncitizen's continued eligibility and benefits.

If the noncitizen receives benefits to which he or she is not entitled because you failed to accurately report information, you and/or the noncitizen may have to repay these benefits.

SPONSOR'S STATEMENT OF FACTS INCOME AND RESOURCES

(Supplement to the SAWS 2, Application For CalFresh And Cash Aid)

COUNTY USE ONLY
CASE NAME: _____
CASE NO: _____
WORKER NO: _____

INSTRUCTIONS: PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOURSELF AND YOUR SPOUSE (IF LIVING TOGETHER OR IF SPOUSE HAS SIGNED AN AFFIDAVIT OF SUPPORT) AND RETURN IT TO THE NONCITIZEN IMMEDIATELY.

Noncitizen Name and Address

Proof may be needed to verify answers to the following questions. Attach proof when the form asks for it.

(1) YOUR NAME (FIRST, MIDDLE, LAST) | TELEPHONE NUMBER ( )

HOME ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)

MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS)

(2) YOUR SPOUSE'S NAME (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT) (FIRST, MIDDLE, LAST) | HAS SPONSOR'S SPOUSE SIGNED AN AFFIDAVIT OF SUPPORT? ☐ Yes ☐ No

(3) Do you or your spouse get assistance such as: CalWORKs/TANF/cash assistance, CalFresh/SNAP/food benefits or Supplemental Security Income (SSI)? If Yes, complete below: ☐ Yes ☐ No

Case Name	Date of Birth	Type of Assistance	County	State

VERIFIED:
☐ Letter on File
☐ Verbal Communication
☐ Other:_____

If **both** you and your spouse get Assistance and the noncitizen is not applying for CalFresh, complete only the Certification section on Page 3 and return the form. For all others, go to Question (4).

(4) A. Have you or your spouse sponsored any other noncitizen's entry into the United States? ☐ Yes ☐ No
If Yes, complete below using the I-864, I-864A or the I-134:

Noncitizen Name	Noncitizen Address	Date of Admission to U.S.

VERIFIED:
☐ Affidavit of Support on File
☐ I-864
☐ I-864A
☐ I-134
☐ Other:_____

B. Are any of the noncitizens listed in (4A) receiving any type of assistance such as: CalWORKs, CalFresh or SSI? ☐ Yes ☐ No
If Yes, complete below:

Type of Assistance	Date First Applied	County	State

☐ Verified
☐ Verified

(5) Do you or your spouse have other persons who are claimed or could be claimed as dependents for federal income tax purposes? ☐ Yes ☐ No
If Yes, complete below:

☐ IRS Form 1040 Reviewed
☐ Other:_____

Name of Person(s)	Does Person Live With Sponsor	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

Claimed ☐ Yes ☐ No
Claimed ☐ Yes ☐ No
Claimed ☐ Yes ☐ No
Claimed ☐ Yes ☐ No
Claimed ☐ Yes ☐ No

(6) Are you or your spouse currently employed? ☐ Yes ☐ No

If Yes, complete section below. Attach paystubs or other proof of earnings. If you or your spouse are self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

COUNTY USE ONLY

Name	Name of Employer	Gross Pay (Before Deductions)	How Often Paid (Weekly, Monthly, etc.)	Commissions or tips	Number of Tax Dependents Claimed	Check if Exempt	Enter Date Viewed: Pay Stubs	Enter Date Viewed: Other
		$		$		☐ Yes ☐ No		
		$		$		☐ Yes ☐ No		

(7) Do you or your spouse receive or expect to receive any other income such as: Social Security, Unemployment/Disability Insurance, Child/Spousal Support, Veterans Benefits, etc? ☐ Yes ☐ No

If Yes, complete section below and attach proof of the income.

Name	Type of Income	Amount	How Often Received	Check if Exempt	Specify Verification and Date Reviewed:
		$		☐ Yes ☐ No	
		$		☐ Yes ☐ No	

(8) Will there be any changes to this income in the next six months? ☐ Yes ☐ No

If Yes, list below what change is expected. Attach any proof you may have such as: a letter from an employer, benefit award letter, etc.

Whose income will change?	What income will change?	How and when will it change?

(9) Do you or your spouse have any of the following resources? Check each item. If Yes, explain below.

Resource	Sponsor	Spouse	Resource	Sponsor	Spouse
Checks or Money (At Home or Elsewhere)	☐ Yes ☐ No	☐ Yes ☐ No	Trust Funds	☐ Yes ☐ No	☐ Yes ☐ No
Checking, Savings, Credit Union Account	☐ Yes ☐ No	☐ Yes ☐ No	Stocks, Bonds, Certificates	☐ Yes ☐ No	☐ Yes ☐ No
Notes, Mortgages, Trust Deeds, Sales Contracts	☐ Yes ☐ No	☐ Yes ☐ No	Other (Specify below)	☐ Yes ☐ No	☐ Yes ☐ No

Type of Resource	Owner	Current Value	Location (Home, Bank, Address, etc.)	Account Number	Check if Exempt
		$			☐ Yes ☐ No
		$			☐ Yes ☐ No
		$			☐ Yes ☐ No

(10) Do you or your spouse own (or are you buying) any real property, such as: a house, land, building, etc. If Yes, complete section below: ☐ Yes ☐ No

Name	Type of Property	Address/Location	How Used? (Home, Rent, etc.)	Balance Owed	Value	Name of Mortgage Co.	Check if Exempt
				$	$		☐ Yes ☐ No
				$	$		☐ Yes ☐ No

Date Registration and Records Viewed

1. _____

2. _____

(11) Do you or your spouse own or use or are you buying any motor vehicles, such as: a car, truck, boat, trailer, van, camper, motorcycle, etc. If Yes, complete, section below: ☐ Yes ☐ No

Name	Year, Make, Model	License Number and State of Registration	Amount of current License Fee	Balance Owed	Check if Exempt
					☐ Yes ☐ No
					☐ Yes ☐ No

Vehicle Valuation

1. $ _____

2. $ _____

(12) Do you or your spouse who receive income pay any court ordered support? ☐ Yes ☐ No

If Yes, enter the monthly amount $_____ Who pays? _____

☐ Verified

(13) Do you or your spouse make support payments to other persons not living in your home? ☐ Yes ☐ No

If Yes, complete section below:

☐ Verified

Who Pays	To Whom Paid (Name)	Amount Paid
		$
		$
		$
		$

(14) Do you or your spouse own or use personal property or resources such as: Jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, other household furnishings. If Yes, complete section below: ☐ Yes ☐ No

Name	Name of Item	Date of Purchase	Purchase Price	Gift	Amount Owed
			$	☐ Yes ☐ No	
			$	☐ Yes ☐ No	
			$	☐ Yes ☐ No	
			$	☐ Yes ☐ No	

Net Market Value

1. _____

2. _____

3. _____

4. _____

CERTIFICATION

- **I understand that if on purpose I don't give the right facts or all the facts for the CalWORKs, CalFresh or cash-based Medi-Cal Programs, I can be punished and I can be legally accused of the crime of fraud. If I am found guilty of committing fraud, I can be fined up to $10,000 for CalWORKs and $250,000 for CalFresh. And, I can go to jail/prison for up to 5 years for CalWORKs and 20 years for CalFresh. In the CalWORKs and CalFresh Programs, my benefits can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years or forever.**
- **I understand that the information provided on this form may be verified by local, state and federal agencies.**
- **I understand that the noncitizen's case, including my statement, may be selected for an additional review to ensure that the noncitizen's eligibility was determined correctly.**
- **I understand that I may be required to repay any benefits which are overpaid because of incorrectly or incompletely reported information.**

- If the noncitizen is applying for Cash Aid, both you and your spouse must sign the form. If the noncitizen is applying for CalFresh benefits only, either you or your spouse must sign the form.

SPONSOR'S CERTIFICATION:

- I understand that the term for Sponsorship is normally an indefinite period of time.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the above information contained on this statement of facts is true, correct, and complete.

SPONSOR'S SIGNATURE OR MARK	DATE
SPONSOR'S SPOUSE'S SIGNATURE OR MARK (IF LIVING WITH SPOUSE OR SPOUSE HAS SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

- If the noncitizen is applying for Cash Aid, the noncitizen must sign this form. If the noncitizen is applying for CalFresh only, the form must be signed by the noncitizen, the head of household, a household member, or an authorized representative.

NONCITIZEN'S CERTIFICATION:

- I have reviewed this signed and completed form from my sponsor(s). I declare under penalty of perjury under the laws of the United States of America and the State of California that it is true, correct, and complete to the best of my knowledge.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources

A. ITEMS	VALUE
	$
	$
	$
	$
	$
B. Total	$

	CW	FS
C. Less: CalFresh Deduction ($1500)	NA	$1500
D. Equals Subtotal =		
E. Total number of sponsored noncitizens applying for/receiving CW/CF		
F. Total (Divide D by E) =		

Amount in F to be included in each noncitizen's property limits.

CalWORKs Sponsor/Sponsor's Spouse Income Computation

A. Earned Income	$
B. Unearned Income	+
C. Subtotal	=
D. Total number of sponsored noncitizens applying for/receiving CalWORKs	
E. Divide C by D	=
F. Number of sponsored noncitizens in this AU	
G. Total (Multiply E by F)	=

Amount in **G** to be deemed income for entire AU.

CalFresh Sponsor/Sponsor's Spouse/Registered Domestic Partner Computation

A. Earned Income	$
B. Less 20%	-
C. Unearned Income	+
D. Gross Income Deduction for Sponsor's household size	-
E. Subtotal	=
F. Total number of sponsored noncitizens replace applying for/receiving Food Stamps	
G. Total (Divide E by F)	=

Amount in G to be deemed income for each sponsored noncitizen.

WORKER SIGNATURE	WORKER SUPERVISOR	DATE

"New" Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

SENIOR PARENT STATEMENT OF FACTS

(Supplement to the SAWS 2)

CASE NAME	
CASE NUMBER	

The rules say that when a minor parent (up to age 18) applies for cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

INSTRUCTIONS:

- Fill in this form and return it with your SAWS 2. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete form, your cash aid and cash-based Medi-Cal may be **changed or stopped.**
- If you have questions, ask your worker or call the county.

1. Does your parent(s) get income, money, or benefits, such as: Earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; interest or dividends from stocks, bonds, savings accounts; In-Home Supportive Services (IHSS); child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc.? ☐ YES ☐ NO

NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		$	
		$	

2. Will there be any changes to this income in the next six months? If "YES", list below what change is expected. Attach any proof they may have such as: a letter from an employer, benefit award letter, etc. ☐ YES ☐ NO

WHOSE INCOME WILL CHANGE?	WHAT INCOME WILL CHANGE?	HOW AND WHEN WILL IT CHANGE?

3. Does your parent(s) support other persons living in the home and claim them as Federal tax dependents? If "YES", list name of person(s) and relationship. ☐ YES ☐ NO

NAME	RELATIONSHIP	NAME	RELATIONSHIP

4. Does your parent(s) support anyone not living in the home and claim or could claim that person as a Federal tax dependent? If "YES", give name of person(s), amount paid and ATTACH PROOF. ☐ YES ☐ NO

NAME	AMOUNT PAID	NAME	AMOUNT PAID
	$		$

CERTIFICATION

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I get more than $950 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.
- I understand that failing to report information or true facts can result in legal prosecution with penalties of a fine, imprisonment or both.
- I understand that I must call my worker to report any unexpected changes which may affect my eligibility for or the amount of my Cash Aid within 5 days of the change. If I am unsure about needing to report any changes, I must contact my worker.
- I understand that the facts I report may result in my benefits being denied, lowered or stopped.
- I understand that I have the right to request a State Hearing on any proposed action by the County Welfare Department.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true, correct, and complete.

YOU MUST SIGN AND DATE THIS REPORT OR IT WILL BE INCOMPLETE

SIGNATURE OF CASH AIDED MINOR PARENT

DATE SIGNED

COUNTY USE ONLY

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

SPONSOR'S QUARTERLY INCOME AND RESOURCES REPORT

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

GIVE THIS TO YOUR SPONSOR

COMPLETE, SIGN, DATE AND RETURN THIS FORM AFTER:

THIS REPORT IS FOR THE MONTH OF

CASE NAME

CASE NUMBER

SPONSOR'S INSTRUCTIONS

- You and your spouse (if living together or if spouse has signed an affidavit of support) must complete and sign this report and return it immediately to the noncitizen you sponsor.
- The noncitizen must complete, sign and date the form, and return it to the county by the 5th of the month. If a complete report, including verification, is not received by the 11th of the month, the noncitizen's Cash Aid may be delayed, lowered, or stopped.
- Call the county if you need help completing this form.

Noncitizen's Name and Address

WORKER: PHONE:

(1) Sponsor's Name (First, Middle, Last)

Answer the following questions for your spouse if she/he is living with you OR has signed an affidavit of support.

(2) Sponsor's Spouse's Name (If Living Together) (First, Middle, Last) | Has sponsor's spouse signed an affidavit of support? ☐ YES ☐ NO

(3) Do you and/or your spouse receive Cash Aid, such as California Work Opportunity and Responsibility to Kids (CalWORKs) or Supplemental Security Income (SSI)? ☐ YES ☐ NO
If YES, complete below.

CASE NAME	DATE OF BIRTH	TYPE OF CASH AID	COUNTY	STATE

(4) During the report month did you and/or your spouse receive income, money or benefits, such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment or disability insurance, interest, worker's compensation, SSI/SSP, child/spousal support, loans, grants, tax refund, cash gifts, free housing/utilities, etc.? ☐ YES ☐ NO

If YES, list who received income, employer's name or other source of income, gross amount before deductions, and actual date received. Attach paystubs or other proof of earnings for the report month. Attach proof of any other income only when it starts and when it changes.

If self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

NAME	SOURCE	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED
NAME	SOURCE	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED

If both you and your spouse (who is living with you) receive Cash Aid, skip to Question 10 and complete the Certification Section.

(5) Since your last quarterly report, did you or your spouse have any changes in personal and/or real property, such as: Receive, buy, sell or give away a motor vehicle, camper, boat, land or house, etc.? ☐ YES ☐ NO
If YES, explain the type of change, date of change and the amount, if applicable.

(6) Did you or your spouse have a checking, savings or credit union account at the end of the report month? ☐ YES ☐ NO
If YES, complete below.

☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month $	Whose Account?	☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month $	Whose Account?

COUNTY USE ONLY WORKER INITIALS DATE

(7) Since your last quarterly report, was there a change in the number of persons who are claimed as dependents for federal income tax purposes by you or your spouse? If YES, complete below. ☐ YES ☐ NO

NAME OF PERSON(S)	DOES PERSON LIVE WITH SPONSOR?	DATE OF CHANGE	EXPLAIN WHAT CHANGED
	☐ YES ☐ NO		
	☐ YES ☐ NO		

(8) Since your last quarterly report, was there any change in payments made to persons who are claimed as federal tax dependents who are not living with you or your spouse? If YES, explain what changed, list the name of the person(s), amount paid and who paid: ☐ YES ☐ NO

(9) During the report month, did you or your spouse pay any court-ordered support? If YES, enter the amount paid and attach receipts: $ ☐ YES ☐ NO

(10) Do you or your spouse have any other information to report such as: a new address, a change in the number of noncitizens that you sponsor and who will receive Cash Aid, recent or anticipated changes in income, etc.? If YES, explain the change and if it is expected to be temporary or permanent, and give the date of change. ☐ YES ☐ NO

CERTIFICATION SECTION

- I understand that the term for Sponsorship is normally an indefinite period of time.
- I understand that failure to report information or misrepresentation of facts for Cash Aid can result in legal prosecution with penalties of a fine, imprisonment or both.
- I understand that I may be required to repay any benefits which are overpaid because of incorrectly or incompletely reported information.

SPONSOR'S CERTIFICATION

- I declare under penalty of perjury under the laws of the State of California that the information contained in this report is true and correct and is complete.

SIGNATURE OF SPONSOR	DATE
SIGNATURE OF SPONSOR'S SPOUSE (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

NONCITIZEN'S CERTIFICATION

- I have reviewed this signed and completed report from my sponsor(s). I declare under penalty of perjury under the laws of the State of California that, to the best of my knowledge, the information contained in this report is true and correct and is complete.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources

			CW	FS
A.	ITEMS	VALUE		
	_____	$_____		
	_____	$_____		
	_____	$_____		
	_____	$_____		
	_____	$_____		
B.	Total	$_____		
C.	Less: Food Stamp Deduction ($1500)	-	NA	$1500
D.	Subtotal	=		
E.	Total number of sponsored noncitizens applying for/receiving CW/FS			
F.	Total (Divide D by E)	=		

Amount in F to be included in each noncitizen's property limits.

CalWORKs Sponsor/Sponsor's Spouse Income Computation

A.	Earned Income	$	
B.	Unearned Income	+	
C.	Subtotal	=	
D.	Total number of sponsored noncitizens applying for/receiving CalWORKs		
E.	Divide C by D	=	
F.	Number of sponsored noncitizens in this AU		
G.	Total (Multiply E by F)	=	

Amount in G to be deemed income for entire AU.

Food Stamps Sponsor/Sponsor's Spouse Income Computation

A.	Earned Income	$	
B.	Less 20%	-	
C.	Unearned Income	+	
D.	Gross Income Deduction for sponsor's household size	-	
E.	Subtotal	=	
F.	Total number of sponsored noncitizens applying for/receiving Food Stamps		
G.	Total (Divide E by F)	=	

Amount in G to be deemed income for each sponsored noncitizen.

"New" Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT MONTH:_____

SPONSOR'S SEMI-ANNUAL INCOME AND RESOURCES REPORT (Supplement to the SAR 7)

TO KEEP YOUR BENEFITS COMING ON TIME, PLEASE GIVE THIS FORM TO YOUR SPONSOR. YOU AND YOUR SPONSOR(S) MUST SIGN AND DATE THIS FORM AFTER THE LAST DAY OF THE REPORT MONTH AND RETURN IT BY **THE 5th OF** _____ (MONTH) **WITH YOUR SAR 7.**

CASE NUMBER

NEED HELP? (County specific instructions w/county unurl)
Worker Name: _____ [Dist. ID here]
Worker Phone : ( ) _____
County:_____
Street Address:_____
City, State, Zip Code_____

Barcode:

SPONSOR'S INSTRUCTIONS

- You and your spouse (if living together or if your spouse has signed an affidavit of support) must complete and sign this report after the end of the Report Month listed at the top of this form and return it immediately to the non-citizen you sponsor.
- Call the county if you need help completing this form.

1. Sponsor's Name (First, Middle, Last)

Answer the following questions for your spouse if he/she is living with you OR signed an affidavit of support.

2. Spouse's Name (First, Middle, Last) | Has spouse signed an affidavit of support? ☐ YES ☐ NO

3. Do you and/or your spouse get cash aid, such as CalWORKs or SSI? If "YES", complete below. ☐ YES ☐ NO

CASE NAME	DATE OF BIRTH	TYPE OF CASH AID	COUNTY	STATE

4. During the Report Month did you and/or your spouse get income, money or benefits, such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment or disability insurance, interest, worker's compensation, SSI/SSP, child/spousal support, loans, grants, tax refunds, cash gifts, free housing/utilities, etc.? ☐ YES ☐ NO

If "YES", list WHO got income, employer's name or other source of income, GROSS amount BEFORE deductions (such as taxes, social security or other retirement deductions, garnishments, support, etc.) and actual date they got the income. Attach paystubs or other proof of earnings for the Report Month. Attach proof of any other type of income only when it starts and when it changes.

If self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

NAME	SOURCE	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED
NAME	SOURCE	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED

5. Will there be any changes to this income in the next six months? If "YES", list below what change is expected. Attach any proof you may have such as: a letter from an employer, benefit award letter, etc. ☐ YES ☐ NO

Whose income will change?	What income will change?	How and when will it change?

If both you and your spouse (if living with you) receive Cash Aid, skip to Question 11 and complete the Certification Section.

6. Since your last report, did you or your spouse have any changes in personal and/or real property, such as: Got, bought, sold, traded, or gave away a motor vehicle, camper, boat, land or house, etc.? If "YES", please explain the type of change and the amount, if applicable. ☐ YES ☐ NO

7. Did you or your spouse have a checking, savings or credit union account at the end of the Report Month? If "YES", complete below. ☐ YES ☐ NO

☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month $	Whose Account?	☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month $	Whose Account?

COUNTY USE ONLY | WORKER INITIALS | DATE

8. Since your last report, was there a change in the number of persons who are claimed as dependents for federal income tax purposes by you or your spouse? If "YES", complete below. ☐ YES ☐ NO

NAME OF PERSON(S)	DOES PERSON LIVE WITH SPONSOR?	DATE OF CHANGE	EXPLAIN WHAT CHANGED
	☐ YES ☐ NO		
	☐ YES ☐ NO		

9. Since your last report, was there any change in payments made to persons who are claimed as federal tax dependents who are not living with you or your spouse? ☐ YES ☐ NO
If "YES", explain what changed, list the name of the person(s), amount paid and who paid:

10. During the Report Month, did you or your spouse pay any court-ordered support? ☐ YES ☐ NO
If "YES", enter the amount paid and attach receipts: $

11. Do you or your spouse have any other information to report such as: A new address, a change in the number of noncitizens you sponsor and who will get cash aid, recent or anticipated changes in income, etc.? ☐ YES ☐ NO
If "YES", explain the change and if you know if it will be temporary or permanent, and give the date of the change.

CERTIFICATION SECTION

- I understand that the term for sponsorship is normally an indefinite period of time.
- I understand that failure to report information or purposely giving the wrong facts for cash aid is a crime and I can be fined, go to jail or both.
- I understand that I may have to pay back any benefits that are overpaid because I did not give all of the facts or gave the wrong information.

SPONSOR'S CERTIFICATION

- I declare under penalty of perjury under the laws of the State of California that the information in this report is true, correct and complete.

SIGNATURE OF SPONSOR	DATE
SIGNATURE OF SPONSOR'S SPOUSE (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

NONCITIZEN'S CERTIFICATION

- I have reviewed this signed and completed report from my sponsor(s). I declare under penalty of perjury under the laws of the State of California that, to the best of my knowledge, the information in this report is true, correct and complete.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY SECTION

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources

A. ITEMS	VALUE
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
B. Total	$_____

	CW	CF
C. Less: CalFresh Deduction ($1500)	- NA	$1500
D. Subtotal	=	
E. Total number of sponsored noncitizens applying for/receiving CW/CF		
F. Total (Divide D by E)	=	

Amount in F to be included in each noncitizen's property limits.

CalWORKs Sponsor/Sponsor's Spouse Income Computation

A.	Earned Income	$ _____
B.	Unearned Income	+ _____
C.	Subtotal	= _____
D.	Total number of sponsored noncitizens applying for/receiving CalWORKs	_____
E.	Divide C by D	= _____
F.	Number of sponsored noncitizens in this AU	_____
G.	Total (Multiply E by F)	= _____

Amount in G to be deemed income for entire AU.

CalFresh Sponsor/Sponsor's Spouse Income Computation

A.	Earned Income	$ _____
B.	Less 20%	- _____
C.	Unearned Income	+ _____
D.	Gross Income Deduction for sponsor's household size	- _____
E.	Subtotal	= _____
F.	Total number of sponsored noncitizens applying for/receiving CalFresh	_____
G.	Total (Divide E by F)	= _____

Amount in G to be deemed income for each sponsored noncitizen.

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

SENIOR PARENT QUARTERLY INCOME REPORT

(Supplement to the QR 7 - Use for unaided senior parent.)

CASE NAME:
CASE NUMBER:
THIS REPORT IS FOR THE MONTH OF:

The rules say that when a minor parent (up to age 18) gets cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

INSTRUCTIONS:

- Fill in this form and return it with your Quarterly Eligibility/Status Report (QR 7) by the 5th day of the submission month. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete report by the 11th day of the submission month, your cash aid and cash-based Medi-Cal may be **delayed**, **changed** or **stopped**.
- If you have questions, ask your worker.

1. During the report month did your parent(s) get income, money, or benefits, such as: earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; interest or dividends from stocks, bonds, savings account; child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc? ☐ YES ☐ NO

   If YES, list who received the money, the source, gross amount before deductions, and actual date received in the report month. Attach paystubs or other proof of your parent's earnings in the report month. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses in the report month. Proof for any self-employment income or other income is needed only when it starts and when it changes.

WHO GOT THE INCOME	SOURCE OF INCOME	GROSS AMOUNT					
			$	$	$	$	$
		ACTUAL DATE RECEIVED					
WHO GOT THE INCOME	SOURCE OF INCOME	GROSS AMOUNT					
			$	$	$	$	$
		ACTUAL DATE RECEIVED					

2. Do your parent(s) expect any changes in income in the next three months? ☐ YES ☐ NO
   If "YES", list below what change is expected. Attach any proof they may have such as, a letter from an employer, benefit award letter, etc.

Who's income will change?	List the source or type of income that will change.	How will the income change?	What do you expect the total amount of income to be in each of the three months?		
			Month_____	Month_____	Month _____

CERTIFICATION

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I received more than $400 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.
- I understand that the facts I report may result in my benefits being changed or stopped.
- I understand that I have the right to a State Hearing on any proposed action by the County Welfare Department.
- I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and are complete.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE MONTH OR IT WILL BE INCOMPLETE.

SIGNATURE OF CASH AIDED MINOR PARENT

DATE SIGNED

COUNTY USE ONLY

"New" Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

SENIOR PARENT SEMI-ANNUAL INCOME REPORT

(Supplement to the SAR 7 - Use for unaided senior parent.)

CASE NAME:
CASE NUMBER:
REPORT MONTH:

The rules say that when a minor parent (up to age 18) gets cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

INSTRUCTIONS:

- Fill in this form and return it with your Semi-Annual Eligibility/Status Report (SAR 7) by the 5th day of the submission month. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete report by the 11th day of the submission month, your cash aid and cash-based Medi-Cal may be **delayed, changed** or **stopped**.
- If you have questions, ask your worker or call the county.

1. During the Report Month did your parent(s) get income, money, or benefits, such as: earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; In-Home Supportive Services (IHSS); interest or dividends from stocks, bonds, savings account; child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc?

   If "YES", list who got the money, the source, gross amount before deductions, and actual date they got it in the Report Month. Attach paystubs or other proof of your parent's earnings in the Report Month. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses in the Report Month. Proof for any self-employment income or other income is needed only when it starts and when it changes.

☐ YES ☐ NO

WHO GOT THE INCOME	SOURCE OF INCOME						
		GROSS AMOUNT	$	$	$	$	$
		ACTUAL DATE THEY GOT IT					
WHO GOT THE INCOME	SOURCE OF INCOME						
		GROSS AMOUNT	$	$	$	$	$
		ACTUAL DATE THEY GOT IT					

2. Will there be any changes to this income in the next six months?
   If "YES", list below what change is expected. Attach any proof they may have such as, a letter from an employer, benefit award letter, etc.

☐ YES ☐ NO

WHOSE INCOME WILL CHANGE?	WHAT INCOME WILL CHANGE?	HOW AND WHEN WILL IT CHANGE?

CERTIFICATION

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I received more than $950 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.
- I understand that the facts I report may result in my benefits being changed or stopped.
- I understand that I have the right to a State Hearing on any proposed action by the County Welfare Department.
- I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and are complete.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE MONTH OR IT WILL BE INCOMPLETE.

SIGNATURE OF CASH AIDED MINOR PARENT	DATE SIGNED

COUNTY USE ONLY

Old Form

State of California - Health and Welfare Agency

Department of Social Services
Department of Health Services

COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDICAL ASSISTANCE

To apply for Cash Aid, Food Stamps, and/or Full or Restricted Medical Assistance, complete items 1-7 on the attached form, and sign the Certification Section (Item 13). Give the form to the welfare office.

Note for Food Stamps: All you have to do the day you apply is give us your name and address (Item 1), tell us you want Food Stamps (Item 2) and sign the application (Item 13). But, before we can tell you if you are eligible, you must give us other facts on this form. You should be told if you are eligible within 30 days after you apply.

Before you can get aid or benefits for Cash Aid, Food Stamps or Medical Assistance; or, for any of the emergencies listed below: AFDC Immediate Need, Food Stamp Expedited Service, Medical Assistance or AFDC Homeless Assistance, you must give us all the facts we ask for during your eligibility interview by either: completing a written Statement of Facts; or, by answering questions during your interview when the county is part of the Statewide Automated Welfare System (SAWS).

If you have an emergency, read below for more facts.

AFDC IMMEDIATE NEED

If you have an emergency, you may be able to get up to $200 of your grant while we work on your application. You will need to tell us about your emergency and show that you don't have the income or money to pay for it. The emergency can be:

-Lack of Housing -Notice of Eviction
-Lack of Food -Essential Clothing
-Utility Shut-Off or Utility Shut-Off Notice
-Essential Transportation Needs
-Other Kinds of Emergencies Important to Health and Safety

To get this payment, you must appear to be eligible for AFDC. Complete Sections A and B on the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your Social Security Numbers, trying to get income available to you, and agreeing to cooperate with the District Attorney about child and spousal support.

If your Immediate Need request is turned down, you can ask again during the time we work on your application. Let the County know if something changes.

FOOD STAMP EXPEDITED SERVICE

You have the right to get Food Stamps within three days.

Your household must be eligible for the Food Stamp Program

AND HAVE

- no place to live or have temporary housing,

OR

- rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions (see the other side of the page for what is income and liquid resources),

OR

- no more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- no more than $100 liquid resources and at least one member who is a migrant or seasonal farmworker.

- Before you can get Food Stamps within three days, complete Sections A and B on the attached form, give us all the facts we ask for during your eligibility interview and give us proof of your identity.

Food Stamps – Date of Eligibility

If you are eligible for Food Stamps, we will figure your benefits from the date you apply. You can apply for Food Stamps the first day you contact the County Welfare Department.

MEDICAL ASSISTANCE

If you have a medical emergency or are pregnant AND want Medical Assistance as soon as possible, complete Section A and Items 8, 9, and 10 in Section B. You must also give all the facts we ask for during your eligibility interview and complete all eligibility requirements.

AFDC HOMELESS ASSISTANCE

If you appear to be eligible for AFDC and are homeless, tell us if you want to apply for homeless assistance.

TURN PAGE OVER TO GET MORE INFORMATION

WHAT WE MEAN WHEN WE SAY:

- You, Anyone, Everyone: any and all persons who live in your home and are applying for Cash Aid, Food Stamps, and/or Medical Assistance. When we need information about the other persons in your home, we will ask you.
- Cash Aid: AFDC (Aid to Families with Dependent Children), and Refugee Cash Assistance.
- Food Stamps - benefits for low income households to help buy food.
- Food Stamp Expedited Service - food stamps within 3 days.
- Medical Assistance - Medi-Cal benefits or any County medical coverage.
- Restricted Medical Assistance - emergency and pregnancy related care only. If you apply for Restricted Medical Assistance, you don't have to give your Social Security Number, place of birth, citizen/alien status, or alien registration number.
- Disqualified - you will not get aid or benefits for a period of time.
- Income - money received or expected, such as:
  - earnings, welfare, child support, SSI or Social Security, pension or retirement payments;
  - Unemployment Insurance (UIB), State Disability (SDI), Veterans (VA) or other disability payments;
  - strike funds, payments from roomers, school grants and loans;
  - cash gifts, cash winnings, any other cash payments.
- Liquid Resources - other money, such as:
  - cash on hand, uncashed checks; money in checking accounts, savings accounts; or savings certificates;
  - trust deeds, notes receivable, stocks or bonds, etc.
- Utilities: gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for Cash Aid and Food Stamps at the same time and have only one interview for both.
- You have the right to fill out this form yourself or have someone help you at your request.
- If you receive too much Cash Aid, Food Stamps, or Medical Assistance, even if it is the County's fault, you will have to pay it back and/or your benefits may be lowered or stopped. Also, if on purpose you give wrong facts or don't report all facts or situations which affect eligibility and aid payments, you may have to pay fines and/or go to jail/prison. Food Stamp recipients can also be disqualified for six months, twelve months or permanently.
- SOCIAL SECURITY NUMBER - Federal rules say that you must give us the Social Security Number (SSN) for each applicant for Cash Aid, Food Stamps and/or Full Medical Assistance. If you refuse to give us either an SSN or proof of application for an SSN, you will be disqualified from getting aid or benefits, but not if you are applying for Restricted Medical Assistance.
- We computer match SSN(s) against records from tax, welfare, employment, the Social Security Administration and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also use the facts you give us to figure eligibility, benefits, and to be sure that you are not getting aid in more than one case.

COMPLAINTS AND STATE HEARINGS

If you have a complaint, try to resolve it with the County. If you can't resolve it, you may call or write to one of the following offices:

Los Angeles
107 South Broadway, Rm. 7125
Los Angeles, CA 90012
Phone (213) 620-4385

Sacramento
744 P Street, MS 16-23
Sacramento, CA 95814
Phone 1-(800) 952-5253
or for the deaf
TDD 1-(800) 952-8349

If you think any action taken by the County is wrong, you can ask for a State Hearing by writing to your local County Welfare Office or by calling the phone numbers listed above. You must ask for a hearing and tell why you want one within 90 days of the action.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDICAL ASSISTANCE (SAWS 1)

Before completing this application, read the Coversheet. You have the right to fill out this form yourself or have someone help you at your request. If you need more space to answer, write on the back of this sheet of paper.

SECTION A - APPLICANT INFORMATION

1 A. Name of Applicant (First, Middle Initial, Last)

B. Social Security Number (SSN) (APPLICANTS FOR RESTRICTED MEDI-CAL BENEFITS DON'T NEED TO GIVE AN SSN)
__ - __ - ____

C. Maiden or Other Name (If Any)

D. Home Address: Number Street

City Zip Code

E. Mailing Address (If different)

City Zip Code

F. Telephone Number(s): Home Work Message

G. Is your home address permanent? ☐ YES ☐ NO ☐ No Home If no home, tell us where you live.

2. Is anyone applying for
Cash Aid ☐ YES ☐ NO
Food Stamps ☐ YES ☐ NO
Medical Assistance ☐ YES ☐ NO
Any Other Program(s)? ☐ YES ☐ NO
If YES, explain:

3. Has anyone ever asked for or gotten aid anywhere? ☐ YES ☐ NO
If YES, explain: under what name, where, when and type(s) of aid.

4. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO
If YES, who?

5. Is anyone pregnant? ☐ YES ☐ NO
If YES, who?

6. Does anyone have a personal emergency? ☐ YES ☐ NO If YES, what kind? Check (✓) below:
☐ Medical ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse ☐ Elder Abuse ☐ Other:

7. The law says we must get your ethnic group and primary language. If you don't want to complete these items, the county will do it for you. This won't affect your eligibility.

a. Ethnic Group - ☐ White ☐ Hispanic ☐ Black ☐ Filipino ☐ Chinese
☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Laotian ☐ Cambodian
☐ Japanese ☐ Korean ☐ Guamanian ☐ Samoan ☐ Vietnamese ☐ Hawaiian
☐ Other Asian or Pacific Islander (specify):

b. Language - ☐ English ☐ Cantonese ☐ Lao ☐ Tagalog ☐ American Sign
☐ Spanish ☐ Cambodian ☐ Vietnamese ☐ Other (Specify):

SECTION B - FOR AFDC, COMPLETE ALL QUESTIONS IF YOU HAVE AN EMERGENCY. FOR FOOD STAMPS, COMPLETE QUESTIONS 8, 9, 10 and 11 IF YOU WANT EXPEDITED SERVICE. FOR MEDICAL ASSISTANCE, COMPLETE QUESTIONS 8, 9, and 10 IF YOU ARE PREGNANT OR HAVE A MEDICAL EMERGENCY.

8. How much liquid resources does everyone have, including children?
☐ Cash, uncashed checks or money orders $ _____
☐ Checking/savings or credit union account(s) $ _____
☐ Trust deeds, notes receivable, stocks or bonds $ _____
☐ Other (explain) $ _____

9. How much income did everyone, including children, get or will they get this month?
$ ____ Date ____ $ ____ Date ____
$ ____ Date ____ $ ____ Date ____

10. How much is your rent or mortgage this month?
$

11. How much are your utilities that are not included in your rent this month? $

12a. Do you have an Eviction Notice or notice to pay or quit? ☐ YES ☐ NO

b. Have your utilities been shut off? ☐ YES ☐ NO

c. Do you have a shut-off notice? ☐ YES ☐ NO

d. Will your food run out in three days or less? ☐ YES ☐ NO

e. Do you need essential clothing, including diapers or clothing needed for cold weather? ☐ YES ☐ NO

f. Do you need help with transportation to get food, clothing, medical care or other emergency item? ☐ YES ☐ NO

g. Do you have another kind of emergency which threatens your health or safety? ☐ YES ☐ NO
If YES, explain:

CERTIFICATION AND PERJURY STATEMENT

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand that the statements I have made on this form may be checked and verified.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.

13. Signature (or Mark) of Applicant or Authorized Representative — Date Signed

Signature of Witness to Mark or Interpreter — Date Signed

COUNTY USE ONLY

COUNTY OF APPLICATION

Co. of Residence (If Diff)

Date Received

Homeless
ES: ☐ YES ☐ NO
AFDC HA: ☐ YES ☐ NO ☐ CA 42

TYPE OF APPLICATION
CA: ☐ AFDC ☐ RCA ☐ ECA
ES: ☐ Initial ☐ Recert ☐ Rest
MA: ☐ Full ☐ Restricted

☐ Referral Date:

Ethnic Group:

Primary Language:

Section B - AFDC IN
☐ Denied/ NOA prep.
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete
By_____ (Initials)

Section B - FS ES
☐ Not completed
☐ Screened for ES
Date_____
By_____ (Initials)

Referred for:
☐ ES Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated
☐ SAWS 1 Coversheet given to applicant

Case Name

Case Number

Current Form

State of California - Health and Human Services Agency

California Department of Social Services
California Department of Health Services

COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office. If you have a disability and need help to apply for or keep getting cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, FOOD STAMPS, OR MEDI-CAL/34-COUNTY CMSP, INCLUDING IMMEDIATE NEED, HOMELESS ASSISTANCE, OR FOOD STAMP EXPEDITED SERVICE, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

FOR CASH AID AND FOOD STAMPS, the county will tell you if and when you need to be fingerprint and photo imaged in order to get benefits.

TO GET IMMEDIATE NEED AND/OR HOMELESS ASSISTANCE, you must appear to be eligible for Cash Aid. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your social security number(s), trying to get income available to you, and agreeing to cooperate with the local child support agency about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another adult household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

FOOD STAMPS — Date of Eligibility
If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

CASH AID IMMEDIATE NEED

If you have an emergency, you may be able to get up to $200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you do not have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

CASH AID HOMELESS ASSISTANCE

If you are homeless, or have received a Pay Rent or Quit Notice, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

CalWORKs DIVERSION SERVICES

Diversion services can help applicants who need some assistance but do not want or need to go on welfare. Diversion services allow you to choose to get a lump sum cash payment or non-cash services instead of going on aid. You can only choose to get Diversion services at time of application for cash aid, and you may be eligible for Medi-Cal, child care assistance, and food stamps if you get Diversion services.

After reviewing your facts, the county will tell you if you would be eligible for Diversion services. If eligible and you choose to get a Diversion cash payment or non-cash services instead of cash aid:

- You will get a denial notice for cash aid.
- Your cash aid may be lowered or the amount of time you can get cash aid may be reduced if you go on aid later.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want food stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE:

- Rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions **(see the other side of the page for definitions of income and liquid resources),**

OR

- No more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- No more than $100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for CalWORKs or Medi-Cal by the end of the month after the month you get a PE card, your temporary Medi-Cal will continue until aid is approved or denied. If you are getting PE, tell the county and check "YES" in both parts of Item 12.

MEDI-CAL/34-COUNTY CMSP - MEDICAL EMERGENCY/PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal/34-County CMSP as soon as possible, complete Items 1-13. You must also give all the facts we ask for during your eligibility interview and meet all eligibility requirements.

WHAT WE MEAN WHEN WE SAY:

- **CalWORKs:** California Work Opportunity and Responsibility to Kids Program.
- **Cash Aid:** Aid from CalWORKs and/or Refugee Cash Assistance (RCA) programs.
- **Diversion Services:** A lump sum cash payment or non-cash services instead of going on cash aid.
- **Food Stamps:** Benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** Getting food stamps within 3 days.
- **Medi-Cal:** Medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** Temporary Medi-Cal coverage from certain doctors or clinics for many out-patient prenatal care services.
- **34-County CMSP:** Medically necessary benefits for eligible adults who are not on Medi-Cal and who live in some rural counties.
- **Restricted Medi-Cal:** Medical Care for emergency and pregnancy only.
- **Restricted 34-County CMSP:** Emergency care only.
- **Authorized Representative:** A person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** A responsible member of the food stamp household.
- **Income:** Money received or expected, such as:
  - Earnings, welfare, child/spousal support, Supplemental Security Income/State Supplementary Program (SSI/SSP), or Cash Assistance Program for Immigrants (CAPI);
  - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
  - Strike funds; payments from roomers and boarders; school grants and loans;
  - Cash gifts, cash winnings, any other cash payments.
- **Liquid Resources:** Money other than income, such as:
  - Cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
  - Trust deeds, notes receivable, stocks or bonds, etc.
- **Utilities:** Gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** Any and all persons who live in your home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid, food stamps and Medi-Cal at the same time and have one interview for all.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **OVERPAYMENTS/OVERISSUANCES:** means you got more cash aid or benefits than you should have gotten. You will have to pay it back even if the county made an error. Your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/34-County CMSP share of cost may be changed.
- **FRAUD AND PERJURY:** Fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting cash aid, food stamps, and Medi-Cal/34-County CMSP. Perjury means that you lied when you swore under oath to give true, correct, and complete facts. If you lie about facts or **on purpose** do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.
- **If you are found guilty of committing fraud, you may be fined up to $10,000 for cash aid and $250,000 for food stamps and/or sent to jail/prison for 3 years for cash aid and 20 years for food stamps. Cash aid and/or food stamps can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, 20 years or forever; and for Refugee Cash Assistance, 3 months and 6 months.**
- **SOCIAL SECURITY NUMBER (SSN) RULES:** We computer match SSNs against records from tax, welfare, employment, the Social Security Administration, and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you are not getting aid in more than one case, or in another county or state; and for cash aid and food stamps, with law enforcement agencies for outstanding arrest warrants.

  Cash aid and food stamps: You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you will not be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.

  Medi-Cal/34-County CMSP: Each applicant for Medi-Cal/34-County CMSP who has a SSN is asked to give it to the county. Any U.S. citizen, U.S. national, amnesty alien with a valid and current I-688, noncitizen with lawful permanent residence in the U.S. (LPR), or noncitizen permanently residing in the U.S. under color of law (PRUCOL) who refuses to give an SSN or proof of application for an SSN, will not be able to get Medi-Cal/34-County CMSP and who is not an amnesty alien with a valid and current I-688 or an LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

COMPLAINTS

If you think you have been discriminated against, contact your county's civil rights representative or write to:
State Civil Rights Bureau
P.O. Box 944243
Sacramento, CA 94244-2430
or call collect (916) 654-2107
or for the hearing or speech impaired
TDD 1 - (916) 654-2098

For other kinds of complaints, contact your county first. If you and the county cannot agree, write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M.S. 6-23
Sacramento, CA 95814
Phone 1 - (800) 952-5253
or for the hearing or speech impaired
TDD 1 - (800) 952-8349

STATE HEARINGS

You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing. You can ask for a State Hearing by writing to your local county appeals office or by calling one of the phone numbers listed for PIAR above, if you:

- Do not agree with any action taken by the county, or
- Are asking for a state hearing for cash aid, food stamps, Medi-Cal.

To appeal all 34-County CMSP eligibility issues, you can **only write** to your county.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)
2. SOCIAL SECURITY NUMBER (SSN)
3. MAIDEN OR OTHER NAME (IF ANY)
2A. DATE OF BIRTH (MM-DD-YYYY)
4. HOME ADDRESS: NUMBER STREET — CITY STATE ZIP CODE
5. MAILING ADDRESS (IF DIFFERENT) — CITY STATE ZIP CODE
6. TELEPHONE NUMBER(S): HOME ( ) WORK ( ) MESSAGE ( )
7. Is your home address permanent? ☐ YES ☐ NO ☐ NO HOME
   If not permanent, please explain:
8. Is anyone applying for: Cash Aid ☐ YES ☐ NO; Medi-Cal ☐ YES ☐ NO; Food Stamps ☐ YES ☐ NO; 34-County CMSP ☐ YES ☐ NO
   Any Other Program(s) ☐ YES ☐ NO If "YES", explain:
9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/34-County CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list: ☐ YES ☐ NO
   TYPE OF AID/BENEFIT — DATE(S) RECEIVED
   NAME(S) USED — RECEIVED WHERE? (COUNTY/STATE/COUNTRY)
10. The law says we must record your ethnic group, race and language. This won't affect your eligibility.
   A. ETHNICITY *(Everyone must also answer B)*
   Are you Hispanic or Latino? ☐ YES ☐ NO
   B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete this question the county will do it for you.
   ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White
   ☐ Asian *(If checked, please select one or more of the following)*
   ☐ Filipino ☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Asian Indian
   ☐ Cambodian ☐ Laotian ☐ Other Asian *(specify)* _____
   ☐ Native Hawaiian or Other Pacific Islander *(If checked, please select one or more of the following)*
   ☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)* _____
   C. PRIMARY LANGUAGE:
   ☐ English ☐ Spanish ☐ Lao ☐ Tagalog ☐ American Sign ☐ Cantonese ☐ Cambodian
   ☐ Vietnamese ☐ Russian ☐ Other *(specify)* _____
11. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO
12. Is anyone pregnant? ☐ YES ☐ NO If "YES", did she get a Presumptive Eligibility card? ☐ YES ☐ NO
13. Does anyone have a personal emergency? If "YES", check (✓) type: ☐ YES ☐ NO
   ☐ Immediate Medical Need ☐ Pregnancy ☐ Child Abuse ☐ Domestic Abuse
   ☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENT ..... FILL IN ITEMS 14 - 18.
FOOD STAMP EXPEDITED SERVICE ..... FILL IN ITEMS 14 - 17.

14. How much liquid resources does everyone, including children, have?
   ☐ Cash, uncashed checks or money orders $_____
   ☐ Checking/savings or credit union account(s) $_____
   ☐ Trust deeds, notes receivable, stocks or bonds $_____
   ☐ Other (explain) $_____
15. How much income did everyone, including children, get or will they get this month?

Date	Amount	Date	Amount
	$		$
	$		$

16. How much is your rent or mortgage this month? $_____
17. How much are your utilities that are not included in your rent this month? $

	YES	NO
18. Do you have an eviction notice or notice to pay or quit?		
Have your utilities been shut off or do you have a shut-off notice?		
Will your food run out in 3 days or less?		
Do you need essential clothing, such as diapers or clothing needed for cold weather?		
Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?		

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.**

19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE — DATE SIGNED

SIGNATURE OF WITNESS TO MARK OR INTERPRETER — DATE SIGNED

COUNTY USE ONLY

CASE NAME

CASE NUMBER

DATE RECEIVED

TYPE OF APPLICATION:
CA: ☐ CA ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ CMSP: ☐

Homeless:
FS: ☐ YES ☐ NO
CA: ☐ YES ☐ NO ☐ CW 42

☐ Pickle Screening

Ethnic Group:

Race:

Primary Language:

CA I.N.
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete SAWS 1
(_____) (Initials)

FS E.S.
☐ E.S. questions not completed
☐ Screened for E.S.
Date_____
(_____) (Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 and coversheet given to applicant

TRANSITIONING CASE NUMBER

COUNTY OF APPLICATION

COUNTY OF RESIDENCE (IF DIFFERENT)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

STATEMENT OF FACTS
CASH AID, FOOD STAMPS AND MEDICAL ASSISTANCE

Old Form 3/22

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER | DATE RCD

Fill in all the questions which tell us about the benefit(s) you are asking for. The programs are listed to the left of each question: "CA" is for Cash Aid, "FS" is for Food Stamps and "MA" is for Medical Assistance. Print all answers in ink. Use proof (such as bills, receipts and records) to help you fill out this form. Give any proof to your worker to help support your answers. If you need help, ask your worker. If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the applicant or other adult member. If you are asking for restricted Medi-Cal benefits, you do not have to answer questions on Social Security Number, birthplace and citizenship/alien status.

CA FS MA **(1) Name of person applying, or caretaker relative of child(ren) for whom aid is wanted.**

HOME PHONE ( )

HOME ADDRESS (NUMBER, STREET) | MAILING ADDRESS (IF DIFFERENT) | DAYTIME PHONE ( )

CITY STATE ZIP CODE | CITY STATE ZIP CODE

☐ New ☐ Restoration
☐ Redeterm ☐ Recert

☐ Residency verified
☐ FS ID ☐ MA ID
☐ FS Aged/Disabled verified

(2) List each adult living in the home, including yourself. List children on page 2 in item 3

SAMPLE

CA FS MA **(A)** APPLICANT'S NAME (FIRST, MIDDLE, LAST)

CITIZENSHIP/IMMIGRATION STATUS (✓)
☐ U.S. Citizen ☐ Lawful Alien—Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

BIRTHPLACE (CITY/STATE/COUNTRY

BIRTHDATE / /

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

MARITAL STATUS (✓)
☐ Married ☐ Never Married ☐ Separated
☐ Divorced ☐ Common Law ☐ Widowed

SFU (✓)	AU (✓)	MFBU (✓)	Fed/State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

☐ SSN verified
☐ Citizen/Alien verified

CA FS MA **(B)** ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZENSHIP/IMMIGRATION STATUS (✓)
☐ U.S. Citizen ☐ Lawful Alien—Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

BIRTHPLACE (CITY/STATE/COUNTRY

BIRTHDATE / /

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

MARITAL STATUS (✓)
☐ Married ☐ Never Married ☐ Separated
☐ Divorced ☐ Common Law ☐ Widowed

SFU (✓)	AU (✓)	MFBU (✓)	Fed/State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

☐ SSN verified
☐ Citizen/Alien verified

CA FS MA **(C)** ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZENSHIP/IMMIGRATION STATUS (✓)
☐ U.S. Citizen ☐ Lawful Alien—Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

BIRTHPLACE (CITY/STATE/COUNTRY

BIRTHDATE / /

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

MARITAL STATUS (✓)
☐ Married ☐ Never Married ☐ Separated
☐ Divorced ☐ Common Law ☐ Widowed

SFU (✓)	AU (✓)	MFBU (✓)	Fed/State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

☐ SSN verified
☐ Citizen/Alien verified

CA FS MA **(D)** ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZENSHIP/IMMIGRATION STATUS (✓)
☐ U.S. Citizen ☐ Lawful Alien—Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

BIRTHPLACE (CITY/STATE/COUNTRY

BIRTHDATE / /

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

MARITAL STATUS (✓)
☐ Married ☐ Never Married ☐ Separated
☐ Divorced ☐ Common Law ☐ Widowed

SFU (✓)	AU (✓)	MFBU (✓)	Fed/State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

☐ SSN verified
☐ Citizen/Alien verified

FS Non-Household/Excluded Member Codes (63-402)

1. Separate household (.12, .13) (Purchase/prepare)
2. Separate household (.15) (Elderly/disabled)
3. Roomer (.211)(must be listed in 13).
4. Live-in attendant (.212)
5. Other (.213) (Shared living quarters)
6. Ineligible alien (.221)
7. Boarder (.3)(must be listed in 13).
8. SSN disqualified (.222)
9. IPV disqualified (.223)
10. Workfare sanctioned (.224)
11. SSI/SSP recipient (.225)
12. Ineligible student (.226)
13. Work requirement disqualified (.227)
14. Questionable citizenship (403.312)

FS Work Exemption Codes (63-407.21)

a. Under 16/60 or older
a(1) 16/17 not head of household; or 16/17 in school/training at least 1/2 time
b. Mentally/physically unfit
c. GAIN registered
d. Cares for child under 6 or incapacitated person
e. UIB registered
f. Participant in drug/alcohol program
g. 30 hour week/min. x 30
h. Meets student eligibility requirements

(3) List each child living in the home. Include children who are out of the home for a short time or who are claimed by you as a tax dependent.

COUNTY USE ONLY

CA FS MA (A) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

BIRTHDATE / /

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

CITIZEN/IMMIGRATION STATUS (✓)
☐ U. S. Citizen ☐ Lawful Alien
Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

MOTHER'S NAME

FATHER'S NAME

CHILDREN NEED AID BECAUSE OF PARENTS' (CHECK (✓) BELOW)

DEATH	DISABILITY	ABSENCE	UNEMPLOYMENT

SFU	AU	MFBU	Fed/ State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

Verified:
☐ Deprivation ☐ Age
☐ Citizen/Alien ☐ SSN

CA FS MA (B) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

BIRTHDATE / /

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

CITIZEN/IMMIGRATION STATUS (✓)
☐ U. S. Citizen ☐ Lawful Alien
Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

MOTHER'S NAME

FATHER'S NAME

SFU	AU	MFBU	Fed/ State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

Verified:
☐ Deprivation ☐ Age
☐ Citizen/Alien ☐ SSN

CA FS MA (C) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

BIRTHDATE / /

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

CITIZEN/IMMIGRATION STATUS (✓)
☐ U. S. Citizen ☐ Lawful Alien
Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

MOTHER'S NAME

FATHER'S NAME

SFU	AU	MFBU	Fed/ State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

Verified:
☐ Deprivation ☐ Age
☐ Citizen/Alien ☐ SSN

CA FS MA (D) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

BIRTHDATE / /

TYPE OF AID REQUESTED (✓)
☐ Cash Aid ☐ Food Stamps ☐ None
☐ Full Medi-Cal ☐ Restricted Medi-Cal

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

CITIZEN/IMMIGRATION STATUS (✓)
☐ U. S. Citizen ☐ Lawful Alien
Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

MOTHER'S NAME

FATHER'S NAME

SFU	AU	MFBU	Fed/ State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

Verified:
☐ Deprivation ☐ Age
☐ Citizen/Alien ☐ SSN

A S A (E) CHILD'S NAME (FIRST, MIDDLE, LAST)

CIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

THPLACE (CITY/STATE/COUNTRY)

BIRTHDATE / /

E OF AID REQUESTED (✓)
Cash Aid ☐ Food Stamps ☐ None
Full Medi-Cal ☐ Restricted Medi-Cal

TIONSHIP TO APPLICANT ARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

CITIZEN/IMMIGRATION STATUS (✓)
☐ U. S. Citizen ☐ Lawful Alien
Sponsored? ☐ YES ☐ NO
☐ Undocumented Alien ☐ Refugee ☐ PRUCOL

IS THIS PERSON BLIND OR DISABLED? ☐ YES ☐ NO

MOTHER'S NAME

FATHER'S NAME

SFU	AU	MFBU	Fed/ State Only	FS Non-HH/Excluded Member Code

Work Registration/Exemption Codes:

AFDC | FS

Verified:
☐ Deprivation ☐ Age
☐ Citizen/Alien ☐ SSN

SAMPLE

CA MA (4) **Does anyone listed above want aid because of pregnancy?** If "YES" complete below: ☐ YES ☐ NO

WHO IS PREGNANT	EXPECTED DATE OF BIRTH / /	FATHER OF THE UNBORN

CHECK (✓) THE BOX(ES) THAT APPLIES TO THE FATHER OF THE UNBORN

☐ Deceased ☐ Disabled ☐ Absent ☐ Unemployed

CA MA (5) **If the other parent(s) of the child(ren) or unborn does not live with you, complete below:**

PARENT NAME	REASON	DATE LAST LIVED TOGETHER
PARENT NAME	REASON	DATE LAST LIVED TOGETHER
PARENT NAME	REASON	DATE LAST LIVED TOGETHER

CA FS MA (6) **Has anyone changed citizen/immigration status in the last 12 months?** If "YES", Who: ☐ YES ☐ NO

WHO	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)

CA FS (7) **Is anyone living in the home a foster child?** If "YES", who: ☐ YES ☐ NO

CA FS MA (8) **Has anyone ever used any other name (maiden, adoptive, etc.)?** If "YES" complete below: ☐ YES ☐ NO

WHO	OTHER NAMES USED
WHO	OTHER NAMES USED

CA FS MA (9) **Does everyone currently live in California and plan to continue living here?** If "NO", explain: ☐ YES ☐ NO

MA (10) **Are you or any family member claimed as a deduction for income tax purposes by a person who does not live with you?** If "YES", who: ☐ YES ☐ NO

NAME	ADDRESS	RELATIONSHIP
NAME	ADDRESS	RELATIONSHIP

CA FS MA (11) **A. Has anyone ever been discontinued from Cash Aid, Food Stamps, Medical Assistance, or due to non-cooperation for any reason, including a quality control review; or because of work or training sanctions?** If "YES", explain below: ☐ YES ☐ NO

WHO	WHY	WHEN	WHAT COUNTY/STATE

FS **B. Has anyone ever been disqualified from the Food Stamp Program for 6 months, 12 months, or permanently because of an Intentional Program Violation(s)?** If "YES", explain below: ☐ YES ☐ NO

WHO	WHY	WHEN	WHAT COUNTY/STATE

FS (12) **Does anyone buy food and fix meals separately from others in the home?** If "YES", explain who: ☐ YES ☐ NO

FS (13) **Is anyone age 60 or older and unable to buy food and fix meals separately because of a disability?** If "YES", explain who: ☐ YES ☐ NO

CA FS (14) **A. Does anyone pay you for meals and/or a room?** If "YES", complete below: ☐ YES ☐ NO

NAME	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	☐ Meals ☐ Room ☐ Both			

B. Do you pay someone else for meals and/or a room? If "YES", complete below: ☐ YES ☐ NO

NAME	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	☐ Meals ☐ Room ☐ Both			

COUNTY USE ONLY

- ☐ Date of Verification
  Special Need
  Effective _____
- ☐ WIC Referral
- ☐ CA 2.1 ☐ CHDP Referral
- ☐ Immediate Need MC Card

- ☐ CA 2.1
- ☐ DA Referral

- ☐ Verif. on File
- ☐ CA 64
- ☐ MC 13

Length of Sanction:

Separate household requested: ☐ YES ☐ NO

Household Elects

BOARDER	HH MEMBER	ROOMER

SAMPLE

FS (15) Does anyone get food from any program such as Meals on Wheels, a food distribution program operated by an Indian reservation, communal dining facility for the elderly or disabled or any other program? ☐ YES ☐ NO
IF "YES", complete below:

WHO	NAME OF PROGRAM

COUNTY USE ONLY

CA FS MA (16) A Does anyone currently live in any of the following: a center, shelter, hospital, subsidized housing for the elderly, nursing home, drug or alcohol rehabilitation center, group living arrangement for the disabled/blind, board and care home, penal institution/correctional facility, or psychiatric hospital/mental institution? ☐ YES ☐ NO
IF "YES", complete below:

FS Eligible Institution ☐ YES ☐ NO

CA Eligible ☐ YES ☐ NO

WHO:	NAME OF CENTER, SHELTER, HOSPITAL, ETC:
DATE ENTERED:	DATE EXPECTED TO LEAVE:

MA B. Does the person who is in a hospital or nursing home have a spouse or minor child at home? ☐ YES ☐ NO

MA C. Does he/she expect to return to his/her primary residence? ☐ YES ☐ NO
IF "YES", complete below:

WHO	WHEN

CA FS MA (17) Is anyone age 16 or older enrolled in school, college, or a training program? ☐ YES ☐ NO
If YES, complete below:

School Enrollment Verif. ☐ YES ☐ NO

Date Verified:

FS Eligible Student ☐ YES ☐ NO

CA FS MA A.

NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM ENROLLED CHECK (✓) ☐ Full time ☐ Half time ☐ Other (specify):	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? ☐ YES ☐ NO
NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM ENROLLED CHECK (✓) ☐ Full time ☐ Half time ☐ Other (specify):	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? ☐ YES ☐ NO

School Enrollment Verif. ☐ YES ☐ NO

Date Verified:

FS Eligible Student ☐ YES ☐ NO

CA FS MA B. Complete below for anyone enrolled in college or attending a similar educational institution.

TERM ☐ Semester ☐ Year ☐ Quarter	TUITION/FEES PER TERM $	BOOKS, EQUIPMENT, ETC., PER TERM $
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED
TRANSPORTATION COST PER WEEK $	AMOUNT PAID BY RIDERS $	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY $

Expenses Verified ☐ YES ☐ NO

Date Verified

CA (18) A. Is anyone 16 through 19 years of age a parent? ☐ YES ☐ NO
IF "YES", complete below:

☐ Referred to GAIN

NAME	AGE	HIGH SCHOOL GRADUATION STATUS. CHECK (✓) ☐ High School diploma ☐ GED ☐ None ☐ Other (explain):
NAME	AGE	HIGH SCHOOL GRADUATION STATUS. CHECK (✓) ☐ High School diploma ☐ GED ☐ None ☐ Other (explain):

CA B. Does this parent's child live in the home? ☐ YES ☐ NO

CA MA (19) Has anyone been in the U.S. Military Service or is anyone the spouse, parent or child of a person who has been in the military service? ☐ YES ☐ NO
If YES, explain: (List name, branch of service, etc.)

☐ CA 5

SAMPLE

CA FS MA **(20) Is anyone working now or expect to be working in the next 2 months?** ☐ YES ☐ NO
(Including children)
If "YES", complete below.
(NOTE: If self-employed, list and explain expenses on a separate sheet of paper and attach it to this form.)

NAME	SELF-EMPLOYED	EMPLOYER NAME	OCCUPATION
	☐ YES ☐ NO		
DAYS/HOURS WORKED PER MONTH	OAT DATE(S)	WAGES BEFORE DEDUCTIONS	TIPS OR COMMISSIONS
		$ per	☐ YES Amount $ ☐ NO
NAME	SELF-EMPLOYED	EMPLOYER NAME	OCCUPATION
	☐ YES ☐ NO		
DAYS/HOURS WORKED PER MONTH	OAT DATE(S)	WAGES BEFORE DEDUCTIONS	TIPS OR COMMISSIONS
		$ per	☐ YES Amount $ ☐ NO

COUNTY USE ONLY
Earnings and Expenses
(✓)Check if exempt

CA	FS	MA	Self-employed farmer?
			☐ YES ☐ NO

☐ Verified

CA	FS	MA	Self-employed farmer?
			☐ YES ☐ NO

☐ Verified

CA FS MA **(21) Does anyone pay for care of a child, disabled adult, or other dependent?** ☐ YES ☐ NO
If "YES", complete below.

WHO RECEIVES THE CARE?	WHO PAYS	AMOUNT/WHEN
		$ every
		$ every

☐ Verified

CA MA **(22) Does anyone pay for child or spousal support?** ☐ YES ☐ NO
If "YES", complete below.

WHO PAYS	FOR WHOM?	AMOUNT PER MONTH
		$ every

Court Order on File? ☐ YES ☐ NO
Amount Ordered
$
Court Petitioned ☐ YES ☐ NO

CA FS MA **(23) Has anyone stopped or refused work or training within the last 60 days?** ☐ YES ☐ NO
If "YES", complete below.

NAME	HOURS OF WORK/TRAINING
	____ ☐ Weekly
	____ ☐ Monthly

NAME AND ADDRESS OF EMPLOYER/PROGRAM

Did he or she get or does he or she expect to get wages or benefits this month? If "YES", complete below. ☐ YES ☐ NO

LAST PAYCHECK RECEIVED (DATE):	AMOUNT BEFORE DEDUCTIONS:
	$
EXPECTED CHECK (DATE):	AMOUNT BEFORE DEDUCTIONS:
	$

LAST DAY OF WORK/TRAINING:

REASON FOR LEAVING JOB/TRAINING:

CA 30 days	FS 60 days	MA 30 days
Empl. Statement	☐ YES ☐ NO	
Good Cause Determ..	☐ YES ☐ NO	
Voluntary Quit?	☐ YES ☐ NO	

FS Vol. Quit or Refusal
☐ Work history last 90 days.

NAME	HOURS OF WORK/TRAINING
	____ ☐ Weekly
	____ ☐ Monthly

NAME AND ADDRESS OF EMPLOYER/PROGRAM

Did he or she get or does he or she expect to get wages or benefits this month? If "YES", complete below. ☐ YES ☐ NO

LAST PAYCHECK RECEIVED (DATE):	AMOUNT BEFORE DEDUCTIONS:
	$
EXPECTED CHECK (DATE):	AMOUNT BEFORE DEDUCTIONS:
	$

LAST DAY OF WORK/TRAINING:

REASON FOR LEAVING JOB/TRAINING:

CA 30 days	FS 60 days	MA 30 days
Empl. Statement	☐ YES ☐ NO	
Good Cause Determ..	☐ YES ☐ NO	
Voluntary Quit?	☐ YES ☐ NO	

FS Vol. Quit or Refusal
☐ Work history last 90 days.

(24) Is anyone on strike? ☐ YES ☐ NO
If "YES", complete below.

NAME OF STRIKER	NAME AN DADDRESS OF EMPLOYER/TRAINING PROGRAM
NAME OF UNION	
DATE WENT ON STRIKE	

Strike Regs Apply ☐ YES ☐ NO
☐ CA ☐ FS ☐ MA

(25) Has anyone applied for or received unemployment or disability insurance benefits in the last 12 months? ☐ YES ☐ NO
If "YES", complete below.

	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED
	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED

SAMPLE

(26) Has any parent living in the home worked or been in training in the past 5 years. If "YES", complete below. ☐ YES ☐ NO

CA FS MA
- Include all work done outside the U.S.
- Include work done in exchange for something besides money, such as rent, food, utilities or anything else.

A. Name: _____
Begin with this person's most recent job or training.

	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed From / / To / / MO DAY YR	Amount Paid	Name and Address of Employer or Training Program (✓) Check, if Work or Training	When Employed From / / To / / MO DAY YR	Amount Paid
1.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
2.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
3.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
4.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly

B. Name: _____
Begin with this person's most recent job or training.

	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed From / / To / / MO DAY YR	Amount Paid	Name and Address of Employer or Training Program (✓) Check, if Work or Training	When Employed From / / To / / MO DAY YR	Amount Paid
1.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
2.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
3.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
4.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8. ☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly

SAMPLE

COUNTY USE ONLY

PRINCIPAL EARNER (PE)	DATE OF APPLICATION	QUARTER OF APPLICATION

PE* eligible or would have been eligible to receive UIB in last 12 months? ☐ YES ☐ NO

Redetermination — Federal eligibility was determined per ☐CA 2 ☐JA 2 ☐SAWS 2 ☐MC210 Date: _____

Do only for the PE*	Begin with the quarter prior to the quarter of application	
		Year
		Quarter
		Work ($50)
		Training (CWEP)WIN DEMO/GAIN)

Are there 6 quarters of work and/or training within any one of the 13 consecutive quarter periods? ☐ YES ☐ NO

The last day PE worked? _____ Case is ☐ Non-Fed ☐ Fed effective _____

*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

COUNTY USE ONLY

Principal earner/UIB requirements

Earnings from month prio to month of application

App Date: _____

Earnings from _____ *to* _____

MO	MO	MO	MO

Total earnings: _____

UIB:

☐ *Must apply for*
☐ *Currently Receiving*
☐ *Ineligible/Reason:*
☐ *Verif. on file*

App Date: _____

Earnings from _____ *to* _____

MO	MO	MO	MO

Total earnings: _____

UIB:

☐ *Must apply for*
☐ *Currently Receiving*
☐ *Ineligible/Reason:*
☐ *Verif. on file*

CA FS MA (27) **A. Has anyone applied for or does anyone get or expect to get money from any of the following sources.** Check (✔) below.

• Training		• Veterans	
-Work study, JTPA		-Disability	
-GAIN or other program		-GI bill	
-Other training allowance		• Military allotment or pension	
• Educational grants, loans and scholarships		• Railroad Retirement	
• Cash Aid		-Disability	
-AFDC		-Retirement	
-Refugee Assistance		• Other private or federal, state, or local government agency	
-GA/GR (General Assistance)		-Disability	
• Worker's Compensation		-Retirement	
• Child/Spousal Support		• Other pension or disability	
• Strike benefits		• Other Insurance Benefits	
• Vacation pay		• Loans, gifts, contributions	
• Unemployment Insurance Benefits (UIB)		• Income from rental property	
• State Disability Insurance (SDI)		• Winnings (bingo, lottery, prizes, etc)	
• Legal or Insurancesettlements/court actions pending		• Sale of property, Contracts, Trust deeds, Promissory notes	
• Social Security		• Jury duty	
-SSI		• Other (Specify)	
-Disability			
-Retirement or survivors			

COUNTY USE ONLY

☐ Casualty Unit Notified
☐ Verif(s) on File
Explain Anticip. Income

☐ DFA 285-C

SAMPLE

If "YES", complete below

WHO	WHAT	AMOUNT (BEFORE DEDUCTIONS, IF ANY)	WHEN	HOW OFTEN

(✔) if exempt

CA	FS	MA

CA FS MA **B. Does anyone expect a change in the current amount of money received now such as a cost-of-living raise?** ☐ YES ☐ NO
If "YES", complete below.

WHO	WHAT	AMOUNT)	WHEN

Verified: ☐ YES ☐ NO

CA FS MA (28) **Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?** ☐ YES ☐ NO
If "YES", complete below.

ITEM RECEIVED	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM
Housing or rent ☐ Free ☐ Exchange		$	
Utilities ☐ Free ☐ Exchange		$	
Food ☐ Free ☐ Exchange		$	
Clothing ☐ Free ☐ Exchange		$	

In-Kind Income
Verif. on file ☐ YES ☐ NO

Partial	Full Earned	Full Unearned
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

CA FS MA (29) **Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?** ☐ YES ☐ NO
If "YES", complete below. Include land and/or buildings in which the title is shared

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	OWNERS	AMOUNT OWED
				$
				$

Home Exempt ☐ YES ☐ NO
Other Real Property
Market Value $_____
Amount Owed $_____
Net Value $_____
Lien Applicable
☐ YES ☐ NO

CA FS MA (30) **A. Does anyone have any of the following resources?**
Check (✔) each item either "YES" or "NO".
- Include all resources owned, used, controlled, shared or held jointly with or for another person(s).
- Include resources on which persons listed in (2) and (3) are named (even for convenience only).
- The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Trust funds (when or for another person(s)		
Uncashed checks (on hand or elsewhere)			Notes, mortgages, trusts, deeds, contracts of sale, etc.		
Saving accounts - children's and adult's			IRA or Keogh plans, etc.		
Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)		
Credit union accounts			Employee deferred compensation plans		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance		
Oil, mining, or mineral rights			Life estate		
Burial/Funeral arrangements or Burial Trusts			Other (explain)		
Income tax refund					

COUNTY USE ONLY

- ☐ Trust Fund/Not Court Ordered
- ☐ Court Petitioned Date _____
- ☐ Resource Verified: Explain how:

Total Value = _____

- ☐ Burial Reserve or Trust
  - ☐ Revocable
  - ☐ Irrevocable
  - ☐ Designated Fund and Current Value $_____

IF YES, COMPLETE BELOW

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	Check (✔) if exempt AFDC	FS

SAMPLE

CA FS MA **B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?** ☐ YES ☐ NO
If "YES", complete below.

WHO	SOURCE OF MONEY	AMOUNT	HOW OFTEN

MA (31) **Are there any liens recorded against any property owned by you or the property of a family member that is used as security for health care services?** ☐ YES ☐ NO
If "YES", complete below.

Verified ☐ YES ☐ NO

LIEN AMOUNT	LOCATION OF PROPERTY	LIEN RECORDED BY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED

CA FS MA (32) **Does anyone own any personal property which costs at least $100, or which is now worth at least $100, such as:**
- boats, 3-wheelers, off-road vehicles, snowmobiles, mobile homes, campers, or trailers
- guns, sporting goods, tools, computers or computer equipment, etc.
- jewelry, artwork, antiques, collections, cameras,musical equipment (pianos, guitars, amplifiers, etc.,)
- pets or livestock

If "YES", complete below.

ITEM	DATE BOUGHT	PURCHASE PRICE: (If a gift check (✔) and list current value)	AMOUNT OWED	ITEM	DATE BOUGHT	PURCHASE PRICE: (If a gift check (✔) and list current value)	AMOUNT OWED
		$ ☐ Gift	$			$ ☐ Gift	$
		$ ☐ Gift	$			$ ☐ Gift	$
		$ ☐ Gift	$			$ ☐ Gift	$

Total Value $_____

CA FS MA (33) **Has anyone sold, spent, traded, or given away any real property such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else?** ☐ YES ☐ NO

(List any property sold or traded within the last 2 years for Cash Aid, within the last 3 months for Food Stamps and within the last 2 1/2 years [30 months] for Medical Assistance).

If "YES", explain what and when:

COUNTY USE ONLY

Closed Bank Accts:

- ☐ Food Stamps in last 3 months
- ☐ Cash Aid in last 2 years
- ☐ Medi-Cal in last 2 1/2 years (30 months.)

CA FS MA (34) **A. Does anyone own or use, or have their name on the registration of any motor vehicles, even if not running?** ☐ YES ☐ NO

If "YES", complete below:

OWNER OF VEHICLE	NAME OF PERSON WHO USES VEHICLE	YEAR, MAKE AND MODEL	LICENSE/STATE OF REGISTRATION	MONTHLY PAYMENT	BALANCE OWED
		CURRENTLY LICENSED? ☐ YES ☐ NO			
		CURRENTLY LICENSED? ☐ YES ☐ NO			
		CURRENTLY LICENSED? ☐ YES ☐ NO			

Commute Vehicle Valuation in County Use Section Below.

- ☐ Exempt
- ☐ Exempt
- ☐ Exempt

CA FS MA **B. Are any of the above vehicles used to go to work, school, or training, or used for transportation of a handicapped person?** ☐ YES ☐ NO

If "YES", complete below:

WHICH VEHICLE	NAME OF PERSON WHO USES VEHICLE	REASON FOR USE

CA FS MA **C. Are any of the above vehicles used as a home?** ☐ YES ☐ NO

If "YES", complete below:

WHICH VEHICLE	NAME OF PERSON WHO USES VEHICLE	LOCATION

COUNTY USE ONLY

Food Stamp Vehicle Valuation

(A)	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)	(B) Values			
Home, income producing or handicap	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	FMV			
Under $4500	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	Minus $4500			
Exempt? For H.H. Use? Work, seek work, school, training?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	Excess Value			
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	FMV			
				Minus Encumbrance			
				Equity Value			

If exempt and under $4500 STOP here; do not go to (B)

FS Vehicle Valuation (Enter date of blue book issue or other documentation)

(1) _____

(2) _____

(3) _____

Total Equity Value:

$

AFDC Vehicle Valuation

Class	(1)	(2)	(3)
Year			
Value			
Amount Owed			
Net Value			
$1500 Exempt: 1 MV Only			
Total Value			
Excess Value			

Medi-Cal Valuation

Vehicle Market Value $ _____

Less Encumbrances $ _____

Net Value $ _____

AFDC—Total ExcessValue:

$

MA—TotalValue:

$

SAMPLE

FS (35) **A. Does anyone have any housing costs?** ☐ YES ☐ NO
If "YES", complete below:

	YES	NO	HOW MUCH	HOW OFTEN BILLED
Rent				
House payment				
Property taxes (if not in house payment)				
Insurance (if not in house payment)				
Other housing costs (explain)				

COUNTY USE ONLY

Verify all housing costs

Total housing $ _____

☐ Shared housing

FS **B. Does anyone else pay all or part of your housing?** ☐ YES ☐ NO
If "YES", complete below:

TYPE OF HOUSING	WHO PAYS	HOW MUCH	HOW OFTEN BILLED

SAMPLE

FS (36) **A. Does anyone have any utility costs?** ☐ YES ☐ NO
If "YES", complete below:

	BILLED YES	BILLED NO	HOW MUCH	HOW OFTEN BILLED
Gas or Electricity (for heating or cooling)			$	
Propane, Oil, Wood, or Other fuel (for heating)			$	
Gas, Electricity or Other fuel (for cooking)			$	
Water			$	
Sewage			$	
Garbage or Trash			$	
Telephone (Basic rate)			$	
Installation of utilities			$	
Other (specify)			$	

Verify client utilities

Total Utilities $ _____

Metered:
☐ YES ☐ NO

Client elects:
☐ Actual ☐ SUA

SUA Prorated:
☐ YES ☐ NO

FS **B. Do you pay heating and/or cooling costs separately from your rent or mortgage?** ☐ YES ☐ NO

FS **C. Does anyone else pay all or part of your utilities?** ☐ YES ☐ NO
If "YES", complete below:

TYPE OF UTILITY	WHO	HOW MUCH ($ OR %)	HOW OFTEN BILLED

FS (37) **You can authorize someone outside your household to pick up your Food Stamps for you or to use them to buy food. If you would like to authorize someone, complete below.**

NAME OF REPRESENTATIVE	ADDRESS	PHONE
		( )

☐ Authorized Representative's I.D. Verified

CA MA (38) Has anyone made a payment for health care services or received medical treatment this month or in the last three months before this month? ☐ YES ☐ NO
If "YES", complete below.

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDI-CAL FOR THOSE MONTHS	
		YES	NO	YES	NO

CA MA (39) Does anyone have MEDICARE coverage? ☐ YES ☐ NO
If "YES", complete below.

PERSON COVERED	MEDICARE CLAIM NUMBER	(✔)	MONTHLY PREMIUM	
			DEDUCTED FROM CHECK	PAID BY YOU
		Part A ☐ Part B ☐	☐ YES ☐ NO	☐ YES ☐ NO
		Part A ☐ Part B ☐	☐ YES ☐ NO	☐ YES ☐ NO

CA MA (40) Does anyone have health, dental, vision, hospitalization or long term care insurance or health plans such as Kaiser, Ross-Loos, Blue Cross, CHAMPUS, etc.? ☐ YES ☐ NO
If "YES", complete below.

INSURANCE COMPANY	PERSON(S) INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			$	
			$	

CA MA (41) Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? ☐ YES ☐ NO
If "YES", complete below.

INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID
		$	
		$	

CA MA (42) Is anyone's health insurance expected to end or has it ended within the last 60 days? ☐ YES ☐ NO
If "YES", complete below.

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			$	
			$	

CA MA (43) Does anyone have a medical condition(s) or situation(s) that requires any of the following considerations?
Check (✔) the item which applies to you.

	YES	NO		YES	NO
Special diet—prescribed by a doctor			No place to live		
Special transportation need			Very high use of utilities		
Special telephone or other equipment			Special laundry service		
Housework (no one in the home can do it)			Other (specify):		

If "YES", explain below.

COUNTY USE ONLY

☐ MC 210A

☐ Dual choice
Explanation given
Referral _____
NA _____

☐ DHS 6155

☐ DHS 6155

☐ DHS 6155

☐ Special verification
☐ Recurring
☐ In-Home Services
☐ Deduction explained

SAMPLE

CA (44) **Does the household want a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances beyond the family's control?** ☐ YES ☐ NO

If "YES", explain:

COUNTY USE ONLY

Special Need Verified:
☐ YES ☐ NO

Eligible for Special Need
☐ YES ☐ NO

CA MA (45) **The following services are free of charge, if you are eligible for Cash Aid and/or Medical Assistance. Your answers to these questions will not affect your eligibility.**

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.

1. Do you want more information about CHDP services? ☐ YES ☐ NO
2. Do you want CHDP medical or dental services? ☐ YES ☐ NO

B. Do you want information about services which may be available to you or about any of the following:

Discrimination, family problems, other living arrangements, alcoholism, drug addiction, or mental/emotional problems, special services for blind or visually impaired children and adults, child care, etc.? ☐ YES ☐ NO

C. Family planning services may be available to help you voluntarily limit family size, decide when you want to have children and prevent unwanted pregnancies. Do you or any member of your family want family planning? ☐ YES ☐ NO

☐ CHDP Brochure and Explanation Given
☐ Refused
☐ Referred
Date _____

☐ Other Service Referral
☐ Referred
Date _____

☐ Family Planning Information Given
☐ Referred
Date _____

SAMPLE

CERTIFICATION

- I understand that any facts I have given, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and employment agencies, etc.
- I understand tha t he county will send information to the Immigration and Naturalization Service (INS) for verification of immigration status and that the information the county gets from INS may affect my eligibility for Cash Aid, Food Stamps and full Medical Assistance.
- **I understand that all facts, including benefit and income facts, that I have given on this form are subject to investigation and review by county, state, and federal personnel, and that if I give wrong facts my Cash Aid, Food Stamps, and Medical Assistance may be denied or discontinued.**
- **I understand the penalties, including the specific disqualification penalties for Food Stamps, for giving wrong or incomplete facts, failing to report facts or situations which may affect my eligibility or benefits for Cash Aid, Food Stamps and Medical Assistance.**
- I understand that the Food Stamp household, any adult member of a Food Stamp household (even if they move out), the sponsor of an alien household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- I understand that my case may be selected for additional review to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this statement of facts is true, correct, and complete.

SIGNATURE (Parent or Caretaker Relative, Food Stamp Household Member or Authorized Representative or Medical Assistance Applicant/Recipient)	DATE SIGNED
SIGNATURE (Other Parent Living in the Home)	DATE SIGNED
SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON COMPLETING FORM FOR PERSON LISTED IN (1) OR (2)	DATE SIGNED

COUNTY USE ONLY

REGULATIONS MET?	CA		FS		MA	
	YES	NO	YES	NO	YES	NO
Residency						
Deprivation						
Age						
Citizen/Alien status						
School enrollment						
Pregnancy verified						
SSN						
Income—Gross and net income						
Property—Within limits and verified amount $						
Work registration						
Sponsored alien						
Federal participation established (If NO, explain)						

FOOD STAMP TESTS

Categorical Eligible ☐ YES ☐ NO

Gross Income Test
Household Size
Gross Monthly Income $
Gross Income Eligible ☐ YES ☐ NO ☐ NA

Separate HH Income Test
Household Size
Gross Monthly Income $
Eligible for Separate HH Status ☐ YES ☐ NO

Aged/Disabled
☐ YES ☐ NO ☐ NA
DFA 285-C
☐ YES ☐ NO

AFDC/MA SFU Size	AU/MFBU Size
☐ INELGIBLE (REASON)	
☐ ELIGIBLE ☐ REDETERMINATION	AUTHORIZATION DATE
ELIGIBILITY CONDITIONS MET-DATE:	EFFECTIVE DATE
ELIGIBILITY WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE	DATE

FS: HH Size:

☐ INELGIBLE (REASON)	
☐ ELIGIBLE ☐ RECERTIFICATION	AUTHORIZATION DATE
ELIGIBILITY WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE	DATE

SAMPLE

Current Form

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH CARE SERVICES

STATEMENT OF FACTS FOR CASH AID, CalFresh, AND MEDI-CAL/34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "CF" for CalFresh (formerly called Food Stamps), and "MC" for Medi-Cal/34-County CMSP listed to the left of each question tell you which questions are for each program.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.
- If you are asking for CalFresh and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER DATE RCD

☐ New ☐ Restoration
☐ Redetermine ☐ Recertification
☐ Residency Verified
☐ CF ID
☐ CF Aged/Disabled Verified
☐ MC ID
☐ MC Minor Consent: Exempt from ID, Residency, SSN, Verifs

CA CF MC (1) **A. Person applying, or caretaker relative of child(ren) for whom aid is wanted. NAME:** HOME PHONE ( )

HOME ADDRESS (NUMBER, STREET) | MAILING ADDRESS (IF DIFFERENT) | DAYTIME PHONE ( )

CITY STATE ZIP CODE | CITY STATE ZIP CODE

CF **B. Are you homeless?** ☐ YES ☐ NO — If "YES": Are you temporarily staying in someone else's home? ☐ YES ☐ NO; If "YES": Give date you began staying at this home:

CA **C. Have you received a pay Rent or Quit Notice?** ☐ YES ☐ NO

(2) **For each ADULT living in the home, give us all the facts.**

CA CF MC (A) ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE (MONTH DAY YEAR) | SOCIAL SECURITY NUMBER

SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO | BIRTHPLACE CITY STATE COUNTRY

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ CalFresh ☐ None ☐ Medi-Cal ☐ 34-County CMSP

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

☐ AU ☐ NON-AU ☐ MFBU
CF Non-HH/Excluded Member Code:
Work Registration/Exemption Codes:
WELFARE to WORK | CF | ABAWD
VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Noncitizen ☐ SAVE
Alien Reg. # | D.O.E.

CA CF MC (B) ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE (MONTH DAY YEAR) | SOCIAL SECURITY NUMBER

SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO | BIRTHPLACE CITY STATE COUNTRY

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ CalFresh ☐ None ☐ Medi-Cal ☐ 34-County CMSP

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

☐ AU ☐ NON-AU ☐ MFBU
CF Non-HH/Excluded Member Code:
Work Registration/Exemption Codes:
WELFARE to WORK | CF | ABAWD
VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Noncitizen ☐ SAVE
Alien Reg. # | D.O.E.

CA CF MC (C) ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE (MONTH DAY YEAR) | SOCIAL SECURITY NUMBER

SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO | BIRTHPLACE CITY STATE COUNTRY

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ CalFresh ☐ None ☐ Medi-Cal ☐ 34-County CMSP

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

☐ AU ☐ NON-AU ☐ MFBU
CF Non-HH/Excluded Member Code:
Work Registration/Exemption Codes:
WELFARE to WORK | CF | ABAWD
VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Noncitizen ☐ SAVE
Alien Reg. # | D.O.E.

COUNTY USE ONLY

CF NON-HH/EXCLUDED MEMBER (63-402)

1. Separate HH (Purchase/prepare) (.12, .13)
2. Separate HH (Elderly/disabled) (.17)
3. Roomer (must be listed in (13)) (.211)
4. Live-in attendant (.212)
5. Other shared living quarters (.213)
6. Ineligible alien (.221)
7. Boarder (must be listed in (13)) (.3)
8. SSN disqualified (.222)
9. IPV disqualified (.223)
10. Workfare sanctioned (.225)
11. SSI/SSP recipient (.226)
12. Ineligible student (.227)
13. Work req. disqualified (.228)
14. Questionable Citizenship (300.51(b))
15. Vol. quit ineligible (408.1, .2)
16. Ineligible/disqualified ABAWD (410.4)
17. Fleeing felon/parole or probation violator (.224)
18. Drug felon (.229)

CF WORK/TRAINING EXEMPTIONS (63-407.21)

a. Under 16/60 or older
a.(1) 16/17 not head of household; or 16/17 in school/training at least 1/2 time
b. Mentally/physically unfit for work
c. Mandatory participant in Welfare to Work activities
d. Cares for child under 6 or incapacitated person
e. Applicant for/recipient of UIB
f. Participant in drug/alcohol program
g. 30 hour week/min. x 30
h. 1/2 time student in school, training or higher education.

CF ABAWD EXEMPTIONS (63-410.3)

1. ABAWD with CF Work/Training Exemption Code 63-407.21
2. Under 18/50 or older (.321)
3. Pregnant (.322)
4. Adult living in HH with dep. child (.323)
5. Lives in ABAWD exempt area (.33)

WtW WORK EXEMPTIONS (42-712)

Age under 16 (.41)
School Attendance (.42)
Age 60 or older (.43)
Disability (.44)
NCR caring for dependent or ward of the court or at risk of FC placement (.45)
Care of another ill or incap member of the household (.46)
Care of child:
- Age 6 months or under (or as allowed under county's CalWORKs plan) (.471)
- Member (who previously claimed .471) upon birth or adoption of subsequent child(ren) (.472)

Pregnancy (.48)
VISTA-full or part time volunteer (.49)

COUNTY USE ONLY

(3) For each CHILD living in the home, child out of the home for a short time, or child you claim as a tax dependent, give us all the facts. If you are pregnant, list child as "unborn" and give due date.

CA CF MC (A) CHILD'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ None

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | MOTHER'S NAME | FATHER'S NAME

CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

AU (✓)	NON-AU (✓)	MFBU (✓)	MFG CHILD	CF Non-HH/Excluded Member Code:
			☐YES ☐ NO	☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | CF

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA CF MC (B) CHILD'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ None

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | MOTHER'S NAME | FATHER'S NAME

CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

AU (✓)	NON-AU (✓)	MFBU (✓)	MFG CHILD	CF Non-HH/Excluded Member Code:
			☐YES ☐ NO	☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | CF

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA CF MC (C) CHILD'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ None

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | MOTHER'S NAME | FATHER'S NAME

CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

AU (✓)	NON-AU (✓)	MFBU (✓)	MFG CHILD	CF Non-HH/Excluded Member Code:
			☐YES ☐ NO	☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | CF

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA CF MC (D) CHILD'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ None

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | MOTHER'S NAME | FATHER'S NAME

CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

AU (✓)	NON-AU (✓)	MFBU (✓)	MFG CHILD	CF Non-HH/Excluded Member Code:
			☐YES ☐ NO	☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | CF

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA (4) List any parent(s) of the child(ren) or unborn who does not live in the home with you.

NAME OF PARENT	REASON THE PARENT DOES NOT LIVE IN THE HOME

COUNTY USE ONLY

☐ Verif. on File
☐ MC 13

CA CF (5) Has anyone changed citizenship/immigration status in the last 12 months? ☐ YES ☐ NO

If "YES", complete below:

NAME	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)

		YES	NO
CA CF (6) A.	**Is a foster child living in the home?** If "YES", who:		
CA CF B.	**Was the child(ren) placed in your home under a dependency order from the court?**		
CA CF C.	**Do you want the foster child(ren) and foster care income counted on the CalFresh case?**		
CA CF MC D.	**Is the child(ren) enrolled in a health care plan?**		

6B: ☐ Request dependency order
6C: ☐ CA and FC elig/CR chooses: Child: ☐ CA ☐ FC CR ☐ CA ☐ None ☐ Kin-GAP
6D: ☐ Medi-Cal ☐ Fee for Service

CA CF (7) Has anyone ever used any other name (maiden, adoptive, etc.)? ☐ YES ☐ NO

If "YES", complete below:

NAME	OTHER NAME(S) USED

		YES	NO
CA MC (8) A.	**Does everyone live in California?** If "NO", explain:		
CA B.	**Does everyone plan to stay in California permanently?**		
CA C.	**Does anyone own, lease or maintain a home outside California?**		
CA MC D.	**Is anyone currently getting public assistance outside California?** If "YES", explain:		
CA E.	**Is anyone planning to leave California for more than 30 days?**		

Calif. Resident: ☐ YES ☐ NO

☐ Property

☐ PA

MC (9) Are you 18 to 21 years of age and claimed as a dependent for income tax purposes? ☐ YES ☐ NO

If Yes, who:

☐ Tax Dependent Letter Sent
☐ CA 2.1

CA CF (10) A. Has anyone's cash aid or CalFresh/SNAP benefits been stopped due to: non-cooperation during a quality control review, work or training sanctions or failure to meet the CalFresh Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason? ☐ YES ☐ NO

If "YES", explain below:

NAME	WHY	WHEN	WHAT COUNTY/STATE

CA CF B. Has anyone's cash aid or CalFresh been stopped for a period of time or forever due to welfare fraud or a CalFresh Intentional Program Violation? ☐ YES ☐ NO

If "YES", explain below:

NAME	WHY	WHEN	WHAT COUNTY/STATE

CF (11) Does anyone living with you buy food and fix meals separately from others in the home? ☐ YES ☐ NO

If "YES", who:

Separate household eligible: ☐ YES ☐ NO

CF (12) Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? ☐ YES ☐ NO

If "YES", who:

Separate household eligible: ☐ YES ☐ NO

CF (13) A. Do you pay someone else for meals and/or a room? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON YOU PAY	CHECK (✔)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	☐ Meals ☐ Room ☐ Both	$		

CA CF B. Does anyone pay you for meals and/or a room? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON WHO PAYS YOU	CHECK (✔)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	☐ Meals ☐ Room ☐ Both	$		

CF (14) Does anyone get food from any of the following programs? ☐ YES ☐ NO
- Communal dining facility for the elderly or disabled
- Food distribution program operated by a Native American reservation
- Other food program

NAME	NAME OF PROGRAM	NAME	NAME OF PROGRAM

CA CF MC (15) A. Does anyone live in any of the following: ☐ YES ☐ NO
If "YES", complete below:
- Shelter, center
- Reservation for Native Americans
- Psychiatric hospital/mental institution
- Group living arrangement for the disabled/blind
- Hospital or nursing home
- Subsidized housing for the elderly
- Drug or alcohol rehabilitation center
- Board and care home
- Penal institution/correctional facility

NAME	NAME OF CENTER, SHELTER, HOSPITAL, ETC.	DATE ENTERED	DATE EXPECTED TO LEAVE

MC B. Does the person who is in a hospital or nursing home have a spouse or other family member at home? ☐ YES ☐ NO

CA (16) List any child age 6-18 who does not attend school regularly and explain why he/she is not attending regularly. ☐ No Child Age 6-18

NAME	REASON NOT ATTENDING SCHOOL REGULARLY

CA CF MC (17) A. Is anyone age 14 or older enrolled in school, college, or a training program? ☐ YES ☐ NO
If "YES", complete below:

NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✔) STATUS	UNITS/HOURS PER WEEK	WORKING
			☐ Full time ☐ Half time ☐ Other (specify):	EXPECTED DATE OF GRADUATION	☐ YES ☐ NO
NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✔) STATUS	UNITS/HOURS PER WEEK	WORKING
			☐ Full time ☐ Half time ☐ Other (specify):	EXPECTED DATE OF GRADUATION	☐ YES ☐ NO

CA CF B. Complete below for anyone enrolled in college or attending a similar educational institution.

NAME	TERM (✔) CHECK STATUS	TUITION/FEES PER TERM	BOOKS, EQUIPMENT, ETC., PER TERM
	☐ Semester ☐ Year ☐ Quarter	$	$

MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE	DAYS ATTENDING PER WEEK	TRANSPORTATION USED

TRANSPORTATION COST PER WEEK	AMOUNT PAID PER WEEK BY CAR POOL MEMBERS	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY
$	$	$

CA (18) A. Is anyone under age 20 and pregnant or a parent? ☐ YES ☐ NO
If "YES", complete below:

NAME	AGE	CHECK (✔) STATUS
		☐ Pregnant ☐ Teen Parent

SCHOOL STATUS, CHECK (✔)
☐ Has a High School Diploma ☐ Has a GED ☐ Not Attending School Regularly (explain):
☐ Currently Attending School Regularly ☐ Other (explain):

CA B. Has anyone received a cash bonus or penalty, or help with child care, transportation, etc. from the Cal-Learn Program? ☐ YES ☐ NO
If "YES", complete below:

NAME	WHERE (COUNTY)	DATE(S) RECEIVED

CA CF (19) Is anyone on strike? ☐ YES ☐ NO
If "YES", complete below:

NAME OF STRIKER	NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM
NAME OF UNION	
DATE WENT ON STRIKE	MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE $

COUNTY USE ONLY

Household Elects		ROOMER
BOARDER	HH MEMBER	

CF Eligible Institution: ☐ YES ☐ NO
CA Eligible: ☐ YES ☐ NO

School Attendence Verified: ☐ YES ☐ NO

School Enrollment Verif.: ☐ YES ☐ NO
Date Verified:
CF Eligible Student: ☐ YES ☐ NO

School Enrollment Verif.: ☐ YES ☐ NO
Date Verified:
CF Eligible Student: ☐ YES ☐ NO

Expenses Verified: ☐ YES ☐ NO
Date Verified:

Financial Aid: ☐ YES ☐ NO
☐ MC 210 S-E

Referred to:
☐ Cal-Learn
☐ CW 25
☐ CW 25A
☐ Referred to Welfare-to-Work

Striker Regs Apply:
☐ CA ☐ CF

CA CF (20) Has anyone, including children, worked or does anyone expect to go to work, including part-time and occasional work? Check (✔) "YES" or "NO" for each item. If "YES", complete below:

	YES	NO
Has anyone stopped or refused work or training within the last 60 days?		
Is anyone working or in training now?		
Does anyone expect to be working or in training in the future? If "YES", what is your anticipated start date?		

If self-employed: **For CalFresh:** List your business expenses on a separate sheet of paper.
For Cash Aid: Check (✔) how you want your business expenses figured each month:
☐ 40% standard deduction ☐ Actual business expenses ☐ Monthly average (yearly business costs divided by 12 months). **If actual,** you must list your business expenses on a separate sheet of paper.

(A) NAME CA CF MC	NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH_____ THIS MONTH_____	EMPLOYER'S NAME AND ADDRESS

PAY DATE(S)	SELF-EMPLOYED	WAGES BEFORE DEDUCTIONS	DATE LAST CHECK RECEIVED	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS
	☐ YES ☐ NO	$ per		☐ YES ☐ NO IF "YES", COMPLETE BELOW

REASON FOR LEAVING JOB/TRAINING	LAST DAY OF WORK/TRAINING	AMOUNT RECEIVED $ / AMOUNT EXPECTED $

DATE NEXT CHECK EXPECTED	AMOUNT EXPECTED BEFORE DEDUCTIONS	OCCUPATION
	$	

WILL THIS INCOME CONTINUE? ☐ YES ☐ NO IF "NO", EXPLAIN ANY KNOWN CHANGES HERE:

(B) NAME CA CF MC	NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH_____ THIS MONTH_____	EMPLOYER NAME AND ADDRESS

PAY DATE(S)	SELF-EMPLOYED	WAGES BEFORE DEDUCTIONS	DATE LAST CHECK RECEIVED	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS
	☐ YES ☐ NO	$ per		☐ YES ☐ NO IF "YES", COMPLETE BELOW

REASON FOR LEAVING JOB/TRAINING	LAST DAY OF WORK/TRAINING	AMOUNT RECEIVED $ / AMOUNT EXPECTED $

DATE NEXT CHECK EXPECTED	AMOUNT EXPECTED BEFORE DEDUCTIONS	OCCUPATION
	$	

WILL THIS INCOME CONTINUE? ☐ YES ☐ NO IF "NO", EXPLAIN ANY KNOWN CHANGES HERE:

CA CF MC (21) A. Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job? ☐ YES ☐ NO
If "YES", complete below and (✔) if for work or training.

WHO GETS CARE	WHO PAYS	WHO GIVES CARE	☐ WORK ☐ TRAINING	AMOUNT PAID/HOW OFTEN
				$ EVERY
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	☐ WORK ☐ TRAINING	AMOUNT PAID/HOW OFTEN
				$ EVERY

CA CF MC B. Does anyone else pay all or part of your child care costs? ☐ YES ☐ NO
Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID	WHO ELSE PAYS	MONTHLY AMOUNT PAID
		$		$
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID	WHO ELSE PAYS	MONTHLY AMOUNT PAID
		$		$

CF MC (22) Does anyone pay child or spousal support? ☐ YES ☐ NO
If "YES", complete below:

WHO PAYS	FOR WHOM	AMOUNT PER MONTH
		$

CA CF MC (23) Has anyone, including children, applied for or received unemployment or disability insurance benefits in the last 12 months OR expect to receive these benefits in the future? ☐ YES ☐ NO
If "YES", complete below:

NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED

CA (24) Has anyone received a Diversion cash payment or non-cash services from any county or other state? If "YES", complete below: ☐ YES ☐ NO

NAME	COUNTY/STATE	AMOUNT RECEIVED	LIST SERVICES RECEIVED	ESTIMATED VALUE OF SERVICES	DATE RECEIVED
		$		$	

COUNTY USE ONLY

(A) (✔) if exempt			CF S/E Farmer
CA	MC	☐ CF Adult ☐ CF Child	☐ Yes ☐ No

(B) (✔) if exempt			CF S/E Farmer
CA	MC	☐ CF Adult ☐ CF Child	☐ Yes ☐ No

☐ Verif(s) on file for: ☐ (A) ☐ (B)

CF: Work history last 120 days ☐ (A) ☐ (B)

(A)	YES	NO
Empl. Statement		
Good Cause Determ		
Voluntary Quit		

(A) ☐ CA: 28 Days ☐ CF: 60 days ☐ MC: 30 days
(B) ☐ CA: 28 Days ☐ CF: 60 days ☐ MC: 30 days

(B)	YES	NO
Empl. Statement		
Good Cause Determ		
Voluntary Quit		

CA: S/E Client Chooses:

(A)	(B)
☐ Actual	☐ Actual
☐ 40% deduction	☐ 40% deduction
☐ Annualize	☐ Annualize

Child Care Informing:
☐ Trustline Informing (CCP 2)
☐ Health & Safety Certification (CCP 5)
☐ Dependent Care Verified

DEP. CARE ELIGIBLE	YES	NO
CF		
MC		

Is there another person in household who could provide care? ☐ YES ☐ NO

If "YES", who: _____

Court Order on File ☐ YES ☐ NO
Amount Ordered:
$

CA CF (25) **Has any parent living in the home worked or been in training in the past 24 months?** ☐ YES ☐ NO

If "YES", complete below:

- Include all work done in and outside the United States (U.S.).
- Include work done in exchange for something besides money, such as rent, food, utilities or **anything else.**
- Include any paid jobs the county helped you to get.
- Begin with each person's most recent job or training.

A. NAME | IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO | IF "YES", LIST TRIBE:

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	4. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
2. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
3. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly

B. NAME | IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO | IF "YES", LIST TRIBE:

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	4. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
2. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
3. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly

CF (26) **Are all CalFresh household members citizens of the United States (U.S.)?** ☐ YES ☐ NO

If "NO", complete below for each CalFresh household member who is **not a citizen of the U.S.**

Name of each noncitizen	A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?	B. While living in the U.S., in how many of the years reported in Column A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?	C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S?
1.			
2.			
3.			
4.			

CA CF MC (27) **Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service?** If "YES", complete below: ☐ YES ☐ NO

NAME	U.S. CITIZEN	(✓) STATUS	HONORABLE DISCHARGE	BRANCH OF SERVICE	DATE OF SERVICE
	☐ YES ☐ NO	☐ ACTIVE DUTY MILITARY/VETERAN ☐ SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	☐ YES ☐ NO		
NAME	U.S. CITIZEN ☐ YES ☐ NO	(✓) STATUS ☐ ACTIVE DUTY MILITARY/VETERAN ☐ SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE ☐ YES ☐ NO	BRANCH OF SERVICE	DATE OF SERVICE

COUNTY USE ONLY

PRINCIPAL EARNER (PE) *	DATE OF APPLICATION	QUARTER OF APPLICATION

*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

COUNTY USE ONLY

PE/UIB Requirements
Earnings from month prior to month of application
App Date: ________
Earnings from ________ *to* ________

MO/YR	(25) A	(25) B
	$	$
TOTAL	$	$

	(25) A	B
Tribal JOBS Referral		
UIB Verif(s) on file		
Must apply for UIB		
Currently Receiving/Got/ or UIB eligible in last 12 months		

UIB Ineligible Reason:

(26) *CF:* ☐ *40 Quarters Verif.*

(27) ☐ *CW 5*

CF: Noncitizen's Honorable Discharge Verif. ☐ *YES* ☐ *NO*

CA CF MC (28) **A. Does anyone, including children, get or expect to get money from any source listed below?** Check (✔) "YES" or "NO" for each item.

	YES	NO		YES	NO
Work Study, Welfare-to-Work, or other program			VA (Veterans) educational related income		
Other training allowance			VA Aid & Attendence		
Educational grants, loans and scholarships			Social Security disability or supplemental security income/state supplementary payment (SSI/SSP)		
CalWORKs/Cash aid from another state			VA disability		
Refugee (RCA) Assistance			Railroad disability		
Cash Assistance Program for Immigrants (CAPI)			Other disability income from a federal, state, or local governmental agency		
GA/GR (General Assistance/Relief)			Other non-government disability or sick leave		
Workers Compensation			Social Security retirement or survivors		
Child/spousal support or money for medical bills or premiums			Railroad retirement		
Strike benefits			Other retirement income from a federal, state, or local governmental agency		
Loans, gifts, contributions			Other non-government retirement income		
Legal or insurance settlements/ court actions pending			Per capita payments		
Sales of notes, contracts, trust deeds, promissory notes			Winnings (gambling/lottery/bingo, prizes, etc.)		
Military allotment or pension			Other (Explain)		

COUNTY USE ONLY

- ☐ Casualty Unit Notified
- ☐ CWC 6041
- ☐ DHS 6155
- ☐ Verif(s) on File
  Explain Anticip. Income

Workers Comp:
☐ Temporary ☐ Permanent

If "YES", complete below:

NAME	SOURCE	(AMOUNT RECEIVED BEFORE DEDUCTIONS)	WHEN	HOW OFTEN
		$		
		$		

(✔) if exempt

CA	CF	MC

CA CF MC **B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise?** ☐ YES ☐ NO
If "YES", complete below:

NAME	WHAT	AMOUNT	WHEN
		$	

CA CF MC (29) **Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?** ☐ YES ☐ NO
If "YES", complete below and check (✔) if free or in exchange for work:

ITEM RECEIVED	Free	For Work	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM
Housing or rent				$	
Utilities				$	
Food				$	
Clothing				$	

In-Kind Income:
Verif. on file: ☐ YES ☐ NO

Partial	Full	Earned	Unearned

CA CF MC (30) **A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?** ☐ YES ☐ NO
If "YES", complete below. Include land and/or buildings in which the title is shared.

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✔)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					$	$
LISTED FOR SALE ☐ YES ☐ NO	RENTAL PROPERTY						
	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO
Other Real Property
Market Value $
Amount Owed $
Net Value $
Lien Applicable ☐ YES ☐ NO
Listed for sale ☐ YES ☐ NO

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✔)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					$	$
LISTED FOR SALE ☐ YES ☐ NO	RENTAL PROPERTY						
	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO
Other Real Property
Market Value $
Amount Owed $
Net Value $
Lien Applicable ☐ YES ☐ NO
Listed for sale ☐ YES ☐ NO

CA MC **B. Does anyone own a house that is not lived in now that he/she hopes to return to someday?** ☐ YES ☐ NO
If "YES", complete below:

OWNER OF PROPERTY	PROPERTY ADDRESS	EXPECTED DATE OF RETURN (IF KNOWN)

Total countable property: Page 7
(List totals on page 9)
CA $
CF $
MC $

CA CF MC (31) **A. Does anyone, including children, have any of the following personal or business-related resources?** Check (✔) each item either "YES" or "NO".
Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Trust funds (whether or not available)		
Uncashed checks (on hand or elsewhere)			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Savings accounts - children's and adult's			IRA or Keogh plans, etc.		
Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)		
Credit union accounts			Employee deferred compensation plans		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance or annuity		
Oil, mining, or mineral rights			Life estate interest in any property		
Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Long term care insurance		
			EBT cash balance from a previous month		
Income tax refund			Other (explain)		

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS-RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	☐ YES ☐ NO				$
	☐ YES ☐ NO				$
	☐ YES ☐ NO				$

CA CF MC **B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?** ☐ YES ☐ NO
If "YES", complete below:

NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN	BUSINESS-RELATED
		$		☐ YES ☐ NO
		$		☐ YES ☐ NO

MC (32) **Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services?** ☐ YES ☐ NO
If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
$			
$			

MC (33) **A. Does anyone own any personal property, such as:** ☐ YES ☐ NO
- Non-motorboats, camper shells, non-motor trailers.
- Guns; tools; or sporting equipment, etc.
- Pets or livestock for personal use.
- Jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms. List jewelry worth more than $100 and household goods or personal items worth more than $500 per item.

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$

MC **B. Does anyone have any business property, including tools, inventory and materials, business equipment, livestock, etc.?** Include any property that is shared or held jointly with any other person(s). If "YES", complete below: ☐ YES ☐ NO

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$

COUNTY USE ONLY

☐ Trust Fund/Not Court Ordered
☐ Court Petitioned
Date _____
☐ Resource Verified:
Explain how:

Total Value = $_____
☐ Burial Reserve or Trust (MCO)
Amount Owed $_____
☐ Revocable
☐ Irrevocable
☐ Designated Fund and Current Value
$_____
☐ CA Restricted Account

Check (✔) if exempt

CA	CF	MC

Verified: ☐ YES ☐ NO
Lien Applicable: ☐ YES ☐ NO
Security Agreement: ☐ YES ☐ NO
MC 174 completed and sent: ☐ YES ☐ NO

☐ Owned Jointly
☐ Owned Separately
☐ Personal Property $500 + for Pickle Program
☐ Insignificant Value for 1931(b)
☐ Listed for sale (Specify):

Total Countable Property: Page 8
(List totals on Page 9)
CA $ _____
CF $ _____
MC $ _____
☐ Listed for sale (Specify):

CA MC CF (34) **Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else?** (List any property sold or traded within the last 12 months for cash aid, 3 months for CalFresh, and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when: ☐ YES ☐ NO

CA MC (35) **Does anyone own, have the use of or have their name on the registration of any motor vehicle, such as: automobile, motorcycle, snowmobile, recreational vehicle, motorboat, etc., even if not running?** If "YES", complete below. Look at your registration to get facts for each vehicle: ☐ YES ☐ NO

	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)
OWNER OF VEHICLE			
NAME OF PERSON WHO USES VEHICLE			
YEAR/MAKE/MODEL			
LICENSE NUMBER			
ESTIMATED VALUE	$	$	$
BALANCE OWED	$	$	$
LICENSED	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
LEASED	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

HOW DO YOU USE THE VEHICLE? Check (✔) each item "YES" OR "NO."	VEHICLE (1) YES	VEHICLE (1) NO	VEHICLE (2) YES	VEHICLE (2) NO	VEHICLE (3) YES	VEHICLE (3) NO
As a Home						
To go to work or training or for job search						
For self-employment, self-support, or business use						
Needed for disabled household member						
To get household's fuel or water						
For recreational use only						

COUNTY USE ONLY

Transfer of Assets:
- ☐ CA in last 12 months
- ☐ CF in last 3 months
- ☐ Medi-Cal in last 30 months

LTC ONLY
- ☐ Adequate Consideration
- ☐ Spenddown

Total Nonexempt Property
$

Compute Vehicle Valuation in Section Below:
- ☐ Verifications viewed
- ☐ Leased vehicle: ☐ (1) ☐ (2) ☐ (3)
- ☐ Pickle Program: Use Pickle Handbook (Reference Section 9)

Vehicle Value
(Enter Date of blue book issue or other documentation)

(1) Date:_____ $_____

(2) Date:_____ $_____

(3) Date:_____ $_____

COUNTY USE ONLY - VEHICLES

CASH AID	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)	☐ YES (Exclude)	☐ NO Go to (B)	☐ YES (Exclude)	☐ NO Go to (B)	☐ YES (Exclude)	☐ NO Go to (B)
(B) (1) Equity: exempt one vehicle, regardless of use. (63-501.523) [If "YES", go to (C). If "NO", go to (B)(2).]	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
(2) Is other vehicle(s) used for job search, employment or training?	☐ YES Go to (C) Use Excess Value	☐ NO Go to (C) and (D) Use Greater Value	☐ YES Go to (C) Use Excess Value	☐ NO Go to (C) and (D) Use Greater Value	☐ YES Go to (C) Use Excess Value	☐ NO Go to (C) and (D) Use Greater Value

(C) Fair Market Values-CA

FMV			
Minus	Minus $4,650	Minus $4,650	Minus $4,650
Excess Value			

(D) Equity Values-CA

FMV			
Minus Encumbrance			
Equity Value			

MEDI-CAL

	(1)	(2)	(3)
DMV/YR/Class Code	_____	_____	_____
Vehicle Market Value	$ _____	$ _____	$ _____
Less Encumbrances	$ _____	$ _____	$ _____
Net Value	$ _____	$ _____	$ _____
Exempt	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Pickle Program (Ref. Sec. 9 in Pickle Handbook):

Is vehicle used:	(1) Exempt	(2) Yes	(2) No	(3) Yes	(3) No
As a home					
For self-employment					
To Go to Work or Medical Appointment					

TOTALS: VEHICLE CA

Excess Value $ _____

Equity Value $ _____

Grand Total Countable Property
(List totals from pages 7, 8, and 9)

Page	CA	CF	MC
(9)	$_____	$_____	$_____
(8)	$_____	$_____	$_____
(7)	$_____	$_____	$_____
Total	$_____	$_____	$_____

CA CF (36) **A. Does anyone have any housing costs?** ☐ YES ☐ NO

If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	$	$	$	
House (mortgage) payment	$	$	$	
Property taxes (if not in house payment)	$	$	$	
Insurance (if not in house payment)	$	$	$	
Other (explain)	$	$	$	

CA CF **B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc.** If "YES", complete below: ☐ YES ☐ NO

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		$	
		$	

COUNTY USE ONLY

Housing verified: ☐ YES ☐ NO

Total housing: $ _____

Shared housing: ☐ YES ☐ NO

CF (37) **A. Does anyone have any utility costs?** ☐ YES ☐ NO

If "YES", please check all boxes below that apply.

Gas		Garbage or trash	
Electricity		Sewer	
Other fuel (such as propane, butane, wood, coal, etc)		Telephone/other means of communication, such as internet, etc.	
Water		Other (explain)	

CF **B. Do you use gas, electricity or other fuel for heating or cooling?** ☐ YES ☐ NO

If 'YES", please check below.

UTILITY	USED FOR HEATING OR COOLING?	
Gas	☐ YES	☐ NO
Electricity	☐ YES	☐ NO
Other Fuel	☐ YES	☐ NO

Utilities verified: ☐ YES ☐ NO

Verification not required ☐

Utility allowance

- ☐ SUA
- ☐ LUA
- ☐ TUA
- ☐ None allowed

CF (38) **You can authorize someone else in your household or someone outside your household to use your CalFresh benefits to buy food for you. If you would like to authorize someone, complete below:**

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		( )

☐ CalFresh I.D. Issued

CA MC (39) Did anyone get medical/pregnancy treatment this month or in the three months before this month? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDI-CAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

CA CF MC (40) Does anyone have MEDICARE coverage? ☐ YES ☐ NO
If "YES", complete below:

PERSON COVERED	MEDICARE CLAIM NUMBER	FOR	(✔) HOW MONTHLY PREMIUM IS PAID		
			DEDUCTED FROM CHECK	OUT OF POCKET	OTHER
		Part A			
		Part B			
		Part A			
		Part B			

CA MC (41) Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans, such as Kaiser, Blue Cross, CHAMPUS, etc.? ☐ YES ☐ NO
If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			$	
			$	

CA MC (42) Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? ☐ YES ☐ NO
If "YES", complete below:

INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID
		$	
		$	

CA MC (43) Is anyone's health insurance expected to end or has it ended within the last 60 days? ☐ YES ☐ NO
If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			$	
			$	

CA MC (44) Does anyone have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

CA CF (45) A. Does anyone have a medical condition(s) or situation(s) that requires any of the following?
Check (✔) each item "YES" or "NO":

	YES	NO		YES	NO
Special diet—prescribed by a doctor			Very high use of utilities		
Special transportation need			Special laundry service		
Special telephone or other equipment			Other (specify):		
Housework (no one in the home can do it)					

If "YES", explain:

CA CF MC B. Is there a child or disabled person in the household who needs care from another household member? ☐ YES ☐ NO
If "YES", explain:

CA MC C. Is anyone a disabled person who is working and who has medical expenses (wheelchair, etc.), which are needed for the person to be able to work? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON	TYPE OF EXPENSE	AMOUNT
		$
		$

CA CF D. Is anyone getting In-Home Supportive Services (IHSS)? ☐ YES ☐ NO
If "YES", who gets service? _____ How much do you pay each month? $_____

COUNTY USE ONLY

Retroactive Application
- ☐ Retro Only
- ☐ Retro and Cont.
- ☐ MC 210A

- ☐ MEDICARE referral

CF: ☐ DFA 285-C
Gross Premium $ _____
- ☐ QMB
- ☐ SLMB/QI
- ☐ QDWI

State Certified LTC Policy: ☐ YES ☐ NO
- ☐ DHS 6155

Benefits Paid Out $_____

- ☐ DHS 6155

- ☐ DHS 6155

- ☐ Third Party Liability

Verified: ☐ YES ☐ NO
Special Need: ☐ YES ☐ NO
Amount: $_____

- ☐ Receipts
- ☐ MC 272 ☐ MC 273

- ☐ IRWE (QMB and SGA)

CF: ☐ DFA 285-C

CA (46) Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire, or flood? ☐ YES ☐ NO
If "YES", explain below.

COUNTY USE ONLY	YES	NO
Special Need Verified		
Eligible for Special Need		

CA CF (47) Are you or any member of the household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? If "YES", give name of the person: ☐ YES ☐ NO

CA CF (48) Have you or any member of your household been found by a court of law to be in violation of probation or parole? If "YES", give name of the person: ☐ YES ☐ NO

CA CF (49) Have you or any member of your household been convicted of a drug-related felony? If No, go to question 50. ☐ YES ☐ NO

CF convictions after 8/22/96
CW convictions after 1/1/98

If Yes, Name: _____ Date convicted: _____ .

Was the conviction for any of the following:

- Transporting, importing into this state, selling, furnishing, administering, giving away, possessing for sale, purchasing for the purposes of sale, manufacturing, or processing precursors with the intent to manufacture a controlled substance or cultivating, harvesting, or processing marijuana? ☐ YES ☐ NO
- Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? ☐ YES ☐ NO

Qualifying Drug Felon?
☐ Yes ☐ No

Meets felony conditions of eligibility?
☐ Yes ☐ No

Have you or any member of your household:

a) Completed a government recognized drug treatment program? ☐ YES ☐ NO

b) Participated in a government recognized drug treatment program? ☐ YES ☐ NO

c) Enrolled in a government recognized drug treatment program? ☐ YES ☐ NO

d) Been placed on a waiting list for a government recognized drug treatment program? ☐ YES ☐ NO

e) Stopped the use of controlled substances and have evidence that you have stopped? ☐ YES ☐ NO

If Yes, please explain: _____

CA MC (50) The following services are available. Your answers to these questions will not affect your eligibility. Check (✔) each item "YES" or "NO."	YES	NO	
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			☐ CHDP Brochure and Explanation Given Date: _____
• Do you want more information about CHDP Services?			☐ CHDP Referral
• Do you want CHDP medical services?			☐ Social Services Referral (MCO)
• Do you want CHDP dental services?			
• Do you need help making appointments or with transportation to CHDP services?			
B. Do you want more information about immunization services?			☐ Referred for Immuniz.
C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?			☐ Pregnant ☐ Parent or Guardian of child under 5
D. Are you breastfeeding a child?			☐ Breastfeeding ☐ Postpartum
If "YES", have you given birth within the last 12 months?			
If you checked "YES" to (50) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			☐ WIC referral
E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.			☐ Family Planning Information Given ☐ Referred Date:

CERTIFICATION

I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and CalFresh, records will be matched with law enforcement agencies for arrest warrants.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, CalFresh, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the U.S. Citizenship and Immigration Services (USCIS) (Formerly INS) to verify immigration status and the facts the county gets from USCIS may affect my eligibility for cash aid, CalFresh, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident noncitizen (LPR), (b) an amnesty alien with a valid and current I-688, or (c) a noncitizen permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the USCIS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The CalFresh household, any adult member of a CalFresh household (even if he/she moves out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime or has been found by a court of law to be in violation of their probation or parole cannot get cash aid or CalFresh.
- Any household member who has been convicted after August 22, 1996 of a drug-related felony for possession, use, manufacturing, sale, distribution of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities, cannot receive CalFresh.
- For cash aid, the county will require that I and certain household members be fingerprint and photo imaged. My benefits may be denied or stopped if I do not cooperate.

I also understand that:

I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, CalFresh, and Medi-Cal.

For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to $10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:
  - For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
  - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
  - For conviction of felony thefts to get aid: 2 years for theft of amounts under $2000; 5 years for amounts of $2000 through $4999.99; and forever for amounts of $5000 or more.
  - For giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing: forever.

For CalFresh:

- If on purpose I do not follow CalFresh rules, my CalFresh will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
  - I traded or sold CalFresh benefits for firearms, ammunition, or explosives, my CalFresh benefits can be stopped forever for the first violation.
  - I traded or sold CalFresh benefits for controlled substances, my CalFresh benefits can be stopped for 24 months for the first violation and forever for the second.
  - I traded or sold CalFresh benefits that were worth $500 or more, my CalFresh benefits can be stopped forever.
  - I filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, my CalFresh benefits can be stopped for 10 years.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT CALFRESH HOUSEHOLD MEMBER OR CALFRESH AUTHORIZED REPRESENTATIVE)			DATE
SIGNATURE (SPOUSE, REGISTERED DOMESTIC PARTNER, OR OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY

ELIGIBILITY FACTORS REVIEWED

	CA		CF		MC	
	YES	NO	YES	NO	YES	NO
Residency						
Deprivation						
Age						
Immunizations						
Citizen/Eligible noncitizen						
School enrollment						
Pregnancy verif./ WIC Referral						
SSN						
Income—Applicant/Recipient test(s)						
SFIS						
TANF Time Limits						
CalWORKs Time Limits						

ELIGIBILITY FACTORS REVIEWED

	CA		CF		MC	
	YES	NO	YES	NO	YES	NO
Property/Resources—Within limits						
Work participation						
Employment & Training (E & T)						
ABAWDs						
CFAP						
Sponsored noncitizen Federal participation established (If "NO", explain)						
Referred for Health Care Options (HCO) Presentation						

CalFresh TESTS

	YES	NO	NA
Categorically Eligible			
Gross Income Test Household Size Gross Monthly Income $			
Gross Income Eligible			
Separate HH Income Test Household Size Gross Monthly Income $			
Eligible for Separate HH Status			
Aged/Disabled			
DFA 285-C			
Gross Income less than $150 and cash on hand, checking and savings accounts of $100 or less?			
Combined gross income and liquid resources less than the combined rent/mortgage and appropriate utility allowance?			
Migrant/seasonal farm worker household with liquid resources not exceeding $100?			

COMMENTS

AU Size:	Non-AU Size:	AU/MFBU Size:

☐ INELIGIBLE (REASON)

☐ ELIGIBLE ☐ DIVERSION
☐ REDETERMINATION ☐ EXEMPT MAP

AUTHORIZATION DATE

ELIGIBILITY CONDITIONS MET (DATE):

EFFECTIVE DATE

WORKER'S SIGNATURE

DATE

SUPERVISOR'S SIGNATURE (COUNTY OPTION)

DATE

CF: HH Size:

☐ INELIGIBLE (REASON)

☐ ELIGIBLE
☐ RECERTIFICATION

AUTHORIZATION DATE

WORKER'S SIGNATURE

DATE

SUPERVISOR'S SIGNATURE (COUNTY OPTION)

DATE

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH CARE SERVICES

RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

For the Cash Aid and CalFresh Programs, and/or Medi-Cal/34-County Medical Services Program (CMSP)

These pages give you your rights and responsibilities and other important information. The county needs your facts to see if you are eligible for cash aid, CalFresh benefits, and/or Medi-Cal/34-County CMSP and to figure how much you will get if you are eligible. If you need more information or have questions, ask your worker.

Cash Aid includes California Work Opportunity and Responsibility to Kids (CalWORKs) and Refugee Cash Assistance (RCA).

Medi-Cal/34-County CMSP includes Full Medi-Cal/34-County CMSP benefits and Restricted Medi-Cal/34-County CMSP emergency and pregnancy related care only.

YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel you have been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

   State Civil Rights Bureau
   744 P Street, MS 8-16-70
   P.O. Box 944243
   Sacramento, CA 94244-2430

   or by calling toll free 1-866-741-6241 or for the hearing impaired TDD 1-800-688-4486.
2. To get help applying for or continuing to receive cash aid, benefits and services if you have a disability. If you need help because of a disability, tell the county.
3. To ask for help to complete your application for any other cash aid, CalFresh, or Medi-Cal/34-County CMSP form.
4. To ask for an interpreter and to have forms and notices translated if you don't speak or read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have your eligibility determined within 45 days for cash aid and Medi-Cal/34-County CMSP (or 90 days for Medi-Cal if a determination of disability is required) and within 30 days for CalFresh benefits.
7. To discuss your case with the county and to review your case yourself when you request to do so.
8. To be told the rules for getting cash aid right away. If we think you might be eligible, you will get an interview within one day.
9. To be told the rules for getting CalFresh benefits right away. If we think you might be eligible to get them right away, you will get an interview immediately and get CalFresh benefits within three days.
10. To get Medi-Cal/34-County CMSP as soon as possible if you have a medical emergency or are pregnant, if eligible.
11. To continue getting cash aid and Medi-Cal benefits without a break if you move from one county to another if you stay eligible.
12. To be told the rules for retroactive Medi-Cal eligibility.
13. To lower any current Share of Cost you may have by giving the county past unpaid medical bills you still owe, when you apply for Medi-Cal.
14. To choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when eligible for Medi-Cal.
15. To ask to have your Medi-Cal Benefits Identification Card (BIC), or EBT card replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible.
16. To ask for extra money if your income drops or stops (cash aid only).
17. To ask for payments for clothing, housing or essential household items which are lost, damaged or otherwise unavailable due to sudden and unusual circumstances (cash aid only).
18. To ask for payments for ongoing special needs like a special diet, transportation for ongoing medical care, special laundry service, telephone for the hard of hearing, high utility bills, etc. (cash aid only).
19. To be notified in writing when your application is approved, denied, or when your benefits change or stop.
20. To have your records kept confidential by the county and state, unless you are getting cash aid or CalFresh benefits and there is a felony arrest warrant issued for you, or as otherwise provided by law.
21. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
22. To ask for a State Hearing within 90 days of the county's action for cash aid, CalFresh benefits and Medi-Cal.
23. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 21 above.
24. To appeal all 34-County CMSP eligibility issues, you can **only write** to your county.
25. To be represented at a State Hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.
26. To have reasonable access to a location where you can withdraw your cash benefits with minimal or no costs.
27. To get a brochure that will tell you how to use your EBT card and how to get your cash benefits at minimal or no costs.
28. To get a list of surcharge-free ATMs and stores where you can get cash back at no cost when you make a purchase with your EBT card. You can get a list of these locations from your county worker or at www.ebt.ca.gov.

YOUR RESPONSIBILITIES

Citizenship/Immigration Status

To sign under penalty of perjury that each member applying for cash aid and CalFresh benefits is a U.S. citizen, U.S. national or has lawful immigration status. Information you give us on immigration status will be checked with the U.S. Citizenship and Immigration Services (USCIS). Information we get from USCIS may affect your eligibility. (Manual of Policies and Procedures Section 42-433).

If you want Medi-Cal/34-County CMSP, you must provide a declaration of citizenship/immigration status under penalty of perjury. If you say you are an noncitizen with lawful permanent residence (LPR) in the U.S., an amnesty alien with a valid and current I-688 or an noncitizen permanently residing under color of law (PRUCOL), your immigration status will be checked with the USCIS. The information the USCIS receives to verify the immigration status of the applicant can only be used to determine Medi-Cal/34-County CMSP eligibility, and cannot be used for immigration enforcement unless you are committing fraud.

Fingerprint/Photo Imaging

All eligible adult household members for cash aid and/or CalFresh benefits must be fingerprint/photo imaged. If anyone who is required to cooperate with these rules does not get fingerprint/photo imaged, no benefits will be issued to the entire household. (Manual of Policies and Procedures Section 40-105.3).

The fingerprint/photo images are confidential and can only be used to prevent or prosecute welfare fraud.

Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for cash aid, CalFresh and Medi-Cal/34-County CMSP may result in repayment of benefits and/or criminal or civil action.

Cash Aid and CalFresh Benefits: You must give us the SSN for each applicant or recipient of cash aid and/or CalFresh. If you refuse to give us either a SSN or proof of application for a SSN, you will not be able to get cash aid or CalFresh benefits. For cash aid, you must give proof of application for a SSN within 30 days of application for cash aid and give the SSN to the county when you get it. (Manual of Policies and Procedures Section 40-105.2).

Each applicant for Medi-Cal/34-County CMSP, who says he/she is a U.S. citizen, a U.S. national, LPR in the U.S., an amnesty alien with a valid and current I-688, or PRUCOL, will be disqualified from getting Medi-Cal if he/she refuses to give either a SSN or proof of application for a SSN. Any noncitizen who does not have a SSN and who is not an amnesty alien with a valid and current I-688 or a LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

Verification(s)

To give proof to support your eligibility. If you can't get proof, you will need to give the name of some other person or agency we may contact to get the proof. We will help you get proof when you can't get it. (Manual of Policies and Procedures Sections 40-105.1; 40-157.212; 40-157.213)

Cooperation

To cooperate with county, state and federal staff. For cash aid, a county worker can come to your home at an arranged time to check out your facts, including seeing each family member. You may not get benefits or your benefits may be stopped if you don't cooperate.

CASH AID AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, Social Security or Medicare, etc.

Child/Spousal and Medical Support

To cooperate with the county and the Local Child Support Agency to:

- identify and locate any absent parent in your case;
- tell the county or the Local Child Support Agency anytime you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- obtain medical support money from any absent parent and, if you get cash aid, obtain child support money;
- give the Local Child Support Agency any medical support money and, any child/spousal support money you get;
- tell the county about medical coverage or money for medical services paid by the absent parent.

Your cash aid will be lowered if you don't cooperate. (Manual of Policies and Procedures Sections 40-157.212; 40-157.213).

MEDI-CAL

Benefits Identification Card (BIC)

- To sign your BIC when you get it and to use it only to get necessary health care services.
- **To never throw your BIC away** (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
- To take the BIC to your medical provider when you or a family member is sick or has an appointment.
- To take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.

Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance you or a family member have.
- To retain any health insurance available to you and your family at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans you have before using Medi-Cal/34-County CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.
- To enroll and stay enrolled in an employment-related group health plan when Medi-Cal approves payment of plan premiums by the State of California.

YOUR REPORTING RESPONSIBILITIES

You must report certain information to the county. If you're not sure how to report, what to report, or what proof we need, ask your worker. If you get CalFresh benefits, your worker will tell you if you are a quarterly or change reporting household. If you get Medi-Cal/34-County CMSP, the county will tell you when you must report. (Manual of Policies and Procedures Section 40-181).

HOW YOU MUST REPORT

For Cash Aid and CalFresh Quarterly Reporting, you must turn in a Quarterly Eligibility Report (QR 7) by the fifth day of the month following your report months and report all required changes to the county within 10 days.

For CalFresh Change Reporting, you must report all changes within 10 days:

- by mail, telephone, or in person at the county CalFresh office; OR
- on a DFA 377.5, CalFresh Household Change Report

For Medi-Cal, you must report all changes within 10 days AND turn in a complete Status Report by the 5th of the month when the county sends or gives it to you.

WHEN YOU MUST REPORT

For Cash Aid and CalFresh Quarterly Reporting

Quarterly reporting rules say that you must report things at certain times. You will be assigned a "report month" for each quarter (three month period). This will be the second month of each quarter. For example, if your quarter is January, February and March, February would be your "report month" and your report would be due by the 5th day of March. The report is always due by the 5th day of the month following your "report month" and will be considered late if not received by the 11th day of the month. If your Quarterly Eligibility Report (QR 7) is late you will have to pay back any cash aid or CalFresh that you were not supposed to get. You will have to report gross income, changes in the number of people in your household, property bought or sold by people in your household and other information for that report month as well as any changes in your gross income that you expect to happen in the next quarter. If you do not turn in a completed Quarterly Eligibility Report (QR 7) by the end of the first working day of the month after the month your report is due, your household's benefits will be stopped.

What you must report on the Quarterly Report:

1. **Earned Income**: All gross earned income received by you or anyone in your household in the report month. This includes wages; tips; vacation pay; cash bonuses; money from self employment or from a training program; also any income in kind in exchange for work, such as free rent, clothing or food.
2. **Unearned or Disability Based Income:** All other income received by you or anyone in your household in the report month. This includes Child/spousal support; interest or dividends; gambling/lottery winnings; insurance or legal settlements; strike benefits; cash, gifts, loans scholarships; tax refunds; any government benefits, like Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), unemployment, worker's compensation, state disability indemnity, veterans or railroad retirement, or other private or government disability or retirement; rental income and rental assistance; free housing/utilities/ clothing/food; or any other type of money received.
3. You must also report on your Quarterly Report any changes in income that you expect to happen during the next quarter. This includes earned, unearned and disability based income changes.
4. **Property:** Any property including, motor vehicles; bank accounts; savings bonds; insurance policies; a home or land; trust; EBT cash balance, etc. that you or anyone in your household has received since your last Quarterly Report and still has, whether it was bought, obtained through a trade or as a gift. The county will use this information to determine if your household exceeds the property limit. You must also report if you or anyone sold, traded or gave away any property since your last Quarterly Report.
5. **If You Move or Someone Moves Into or Out of Your Home:** Anyone (including newborns) who moved into your home since your last Quarterly Report and is still there. You must also report anyone who moved out of your home or who has died since your last Quarterly Report.
6. **Convicted Drug Felons, Fleeing Felons and Probation/ Parole Violators:** The name of anyone in your household who is either avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole. You must also report any household member who has been convicted of a drug felony for possession, use, manufacturing sale or distribution, of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in these activities. For CalFresh you must report felonies since August 22, 1996 and for cash aid list convictions that happened after January 1, 1998.
7. **Reduced Hours of Work:** If you are an Able-Bodied Adult Without Dependents (ABAWD), you must report when your hours of work drop below 20 hours a week or 80 hours a month. You must also report if you expect your work hours to drop below these limits during the next three months.

For Medi-Cal/34-County CMSP, you must report when:

1. Anyone enters or leaves a nursing home or long term care facility.
2. Anyone applies for disability benefits, such as SSI/SSP, Social Security, Veterans, or Railroad Retirement.
3. Anyone gets health care services that result from an accident or injury due to someone else's action or failure to act.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

For Non-Assistance CalFresh Quarterly Reporting

If you only get CalFresh benefits you must report when:

1. Anyone in the household moves to another address, plans to move or gets a new mailing address.
2. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

For CalWORKs you must report certain changes at other times:

In certain circumstances you will be required to report things (within ten days of the change) even if it is not your "report month" such as:

1. Anytime that your family's combined gross income (both earned and unearned) is more than the Income Reporting Threshold (IRT) for a family of your size. Your county worker will tell you the IRT limit for a family of your size. If your family only gets unearned income or only gets CalFresh benefits, you will only be required to report income on your Quarterly Eligibility Report (QR 7).
2. Anytime that someone in your household is convicted of a drug related felony, becomes a fleeing felon or is in violation of probation or parole.
3. Anytime you move you must report your address change so that the county will know where to send your benefits, Quarterly Report forms and notices.

Reporting information voluntarily for CalWORKs and CalFresh Quarterly Reporting:

You may also report other information voluntarily even when it is not your "report month." Reporting information voluntarily may cause your household's benefits to go up. If the information reported causes your benefits to go up, the county will take action within ten days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the county will take action to increase benefits the first of the month after you provide verification. Even if you have already reported something to the County, you must also report it on your next Quarterly Report (QR 7).

Some examples of voluntary reporting that may cause your benefits to go up include:

- Your income stops or drops.
- Someone who has little or no income moves into your home (including a newborn).
- Someone who has income moves out of your home.
- You believe that you or someone in your household is eligible for a CalWORKs Special Needs payment, such as pregnancy special needs or a qualifying special diet.

Additional examples for CalFresh only:

- A household member begins to pay court ordered child support for a child not living in the home.
- A household member is 60 or older.
- Any member who is disabled or 60 years of age or older has changes in or new medical expenses (if verified your CalFresh can be refigured).

Additional Information for CalFresh Only Households

If you receive CalFresh benefits and you voluntarily report income that has increased, and it is above the gross income level for your household size, your benefits may be discontinued.

Note that if you receive only CalFresh benefits: (1) you do not have to report any increases in income during the quarter; and, (2) when you report changes to the county or in between written quarterly reports, you must also report the change on your next QR 7.

At anytime you can ask the county to discontinue your entire case or any individual person who has left the home or is not required to be in the assistance unit. You can also ask the county to discontinue certain benefits, such as: Medi-Cal or CalFresh. Receiving Medi-Cal/or CalFresh only will not count against your cash aid time limits.

Other changes for quarterly reporting:

There are other changes that will cause the county to decrease or discontinue your benefits during the quarter in which they happen. Here are some examples:

- An adult in the household reaches the CalWORKs 48-month time limit;
- A household member is sanctioned/penalized;
- A child reaches the age of 18 (and will not graduate from high school before the age of 19);
- Someone in your household begins receiving benefits in another household;
- An eligible child is placed in Foster Care;
- Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

CALFRESH CHANGE REPORTING

For CalFresh Change Reporting, you must report when:

1. Your total monthly income starts, stops, or changes by more than $50.
2. Anyone's source of income changes.
3. Anyone moves into or out of your home.
4. Anyone joins or leaves your household.
5. You move or you get a new address.
6. Your rent and utility costs **only** if you move.
7. Anyone buys, gets, sells, or gives away a licensed motor vehicle.
8. If there is a change in the amount of any court ordered child support paid by a member of the household for a child not living in the home.
9. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.
10. Any member of your household is avoiding or running from the law to avoid any felony prosecution, custody or confinement after conviction, or is in violation of probation or parole.
11. Any household member convicted of a drug-related felony after August 22, 1996, for manufacturing, sale or distribution of a controlled substance(s), or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities.

For CalFresh Change Reporting, you may report when:

1. Anyone's physical or mental illness begins or ends.
2. Anyone's citizenship/immigration status changes or anyone gets a letter, form or new card from the USCIS.
3. You have changes in your dependent care costs.
4. Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.
5. Any household member starts to pay court ordered child support for a child not living in the home.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

IMPORTANT INFORMATION CASH AID ONLY

Unemployed Parent

If you are applying for cash aid as an unemployed parent, the principal earner (PE) must:

- be unemployed and not have worked in the preceding 4 weeks
- apply for and accept any unemployment insurance you are eligible to receive

The PE is the parent who has the most earnings in the past 24 months.

Homeless Assistance

You may be eligible for money to help pay for temporary shelter, permanent housing or to prevent eviction. This is a once-in-a-lifetime payment unless you meet an exemption. If you have already received homeless assistance and need it again, your worker will tell you if you are eligible.

School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children are attending school, and
- children under the age of 6 have received age appropriate immunizations. (Manual of Policies and Procedures Sections 40-105.4; 40-105.5).

Maximum Aid Payment (MAP)

There are two levels of Maximum Aid Payment (MAP). Most families getting cash aid get the lower MAP level. Families may get the higher MAP level if each parent or caretaker in the Assistance Unit (AU):

- is disabled and getting Supplemental Security Income/ State Supplemental Payments (SSI/SSP), or In-Home Supportive Services (IHSS), or State Disability Insurance (SDI), or Temporary Workers Compensation (TWC), or Temporary Disability Indemnity (TDI) benefits
- is caring for an aided child(ren) who is not their child and the caretaker does not get cash aid.

Also eligible for the higher MAP:

- a family who gets Refugee Cash Assistance (RCA) if each adult meets an exception.

If all the adults in the household meet at least one of these exemptions, ask your worker about applying for an exemption.

Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of your gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

Maximum Family Grant (MFG) Rule

The MFG rule applies to any child born after August 31, 1997. The MFG rule says that your maximum aid payment (MAP) will not go up to include a child born to your family, if your family got cash aid for the 10 months in a row right before the child's birth. There are exemptions to the rule. Your worker will give you a copy of the MFG rules and answer your questions. Then you will sign a copy that says you understand the rules.

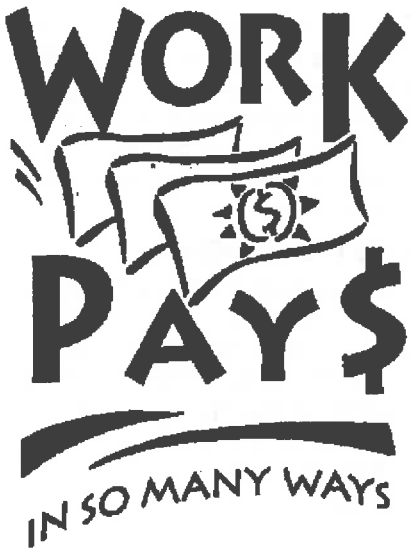
Proof of Facts

If you ask for cash aid within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for cash aid within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since you last got cash aid, the county will need new proof.



Here's how **Work Pays:**

- Gives you more $$$$ to help support your family
- Builds a better life for you and your family
- Develops job skills
- Builds self-esteem
- Gives you personal satisfaction

You can work and still get cash aid:

✔ In most cases, when you work, your gross earnings (earnings before deductions) are not subtracted dollar for dollar from your cash aid payment. You may be eligible for **work related deductions**. When you add it up, you have more $$$$ for your family.

✔ When you have a **grant-based on the job training (OJT)** assignment, all or part of your cash aid payment is used by your employer to help pay your wages. You do not get work related deductions for grant based OJT wages.

✔ Either way, you may be eligible for child care costs that are paid to your provider.

See page 7 for facts about work and training rules, work incentives, including child care programs. Ask your worker for more facts about **Work Pays** and how **grant-based OJT** can work for you.

Remember, you can work and still get cash aid as long as you stay eligible and meet reporting rules in a timely manner.

Work and Training Rules

Your worker will tell you what cash aid and/or CalFresh work rules you need to follow before and after your application is approved. You may be required to be in work, training or education activities to keep getting your cash aid, CalFresh, or both. More than one member of a household can be required to follow cash aid and/or CalFresh work rules. If anyone becomes ineligible for not following work or training rules, other members of their household can still get cash aid or CalFresh, as long as they remain eligible. But, the amount of cash aid or CalFresh they get may change.

Cash Aid Work Rules

If you get cash aid and CalFresh benefits or just get cash aid, you will need to take part in certain Welfare-to-Work activities to keep getting your cash aid and CalFresh benefits. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules. Welfare-to-Work activities include, but are not limited to, subsidized or unsubsidized work, work experience, community service, adult basic education, vocational training, and job search. Subsidized means that the county or some other funding source pays your employer for part of your wages.

The cash aid work rules also say you must:
- Sign a Welfare-to-Work plan;
- Take a suitable job that is offered to you;
- Not quit a job or reduce your earnings.

Sanctions for Not Meeting Cash Aid Work Rules

Any time you don't meet cash aid work rules for a good reason, your cash aid will be stopped until you do what you should do. After your cash aid is stopped or reduced, you can only get it back again if you meet the work rules that you had stopped meeting or you become excused. If your cash aid is stopped, your CalFresh benefits may also be stopped or reduced.

CalFresh Work Rules for Persons Not Receiving Cash Aid

If you only get CalFresh benefits, you may need to take part in certain employment and training activities to keep getting your CalFresh benefits. These activities include job search, workfare, adult basic education, and vocational training. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules.

The CalFresh work rules also say you must:
- Answer questions about your job experience and ability to work;
- Check on a possible job we tell you about and take a suitable job that is offered to you;
- Not quit a job or reduce the number of hours you work to less than 30 hours per week.

CalFresh Only Penalties

If you don't meet CalFresh work rules and you don't have a good reason, your CalFresh benefits will be denied or stopped for one, three, or six months, depending on the number of times you stop meeting the rules. After your CalFresh benefits are stopped, you can only get them again at the end of the penalty or sooner if you become excused.

Work Requirement for Able-Bodied Adults Not Receiving Cash Aid

If you only receive CalFresh benefits and you don't have minor children, there is another work rule which you also may need to meet. You do not have to meet this work rule if you are under age 18, over age 49, pregnant, or you are part of a CalFresh household with a minor child. You may be excused for other reasons that your county worker can explain. The work rule says that if you are an able-bodied adult, you must work at least 20 hours a week or 80 hours a month in paid employment, take part in a workfare project for the required number of hours, or take part in an approved training activity for at least 20 hours per week or 80 hours per month. During a period of 36 months, CalFresh benefits will stop if there are three months in which you do not meet the work rule. If you stop meeting the work rule a second time for reasons such as being laid off, you may be able to get CalFresh benefits for three months in a row without having to meet the rule. After that you can only get CalFresh benefits if you meet the work rule or get excused.

CalWORKs Income Disregards

The total amount of cash aid your family receives is based on your family size and any other income you may have. The law allows for some income to be disregarded when the total amount of cash aid you will receive is calculated.

- If your family gets more than $225 a month of Disability Income (DI), only the first $225 is disregarded.
- If your family gets $225 a month or less of DI, none of it will be counted as income and if you also have Earned Income (EI), any remaining amount of the $225 disregard, up to $112, will not be counted as income.
- In addition, 50 percent of any other EI will be disregarded.
- The remainder is your net countable income and is the amount that will be used to figure your cash aid.

Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

CalWORKs Child Care Program

Child care benefits are available to recipients who need child care to work or participate in county-approved welfare-to-work activities such as attending education or job training programs.

California Department of Education (CDE) Child Care

Child care benefits are also available from CDE. Contact your local Resource and Referral Agency for more information.

Transitional Medi-Cal (TMC)

You may get Medi-Cal for up to 12 months if you go off cash aid because you are working. Your family must have gotten cash aid for at least three of the last six months before cash aid stopped. To get more than six months of TMC, your income must be under certain limits and you must meet TMC reporting rules.

OTHER IMPORTANT INFORMATION

CASH AID AND CALFRESH QUARTERLY REPORTING HOUSEHOLDS
Budgeting Rules

The amount of cash aid and/or CalFresh benefits you can get depends on your income and allowable expenses. You will get a Quarterly Eligibility Report (QR 7) to fill out every three months. On the QR 7, you will need to report what income and expenses you had in the last month and what income and expenses you think you will have in the three months after you turn in your report. The income and expenses you expect to have in the next three months will be used to figure the amount of cash aid and/or CalFresh benefits you can get for those three months. Information that you put on the QR 7 about the past month will be used for the next three months if you don't expect your income or expenses to change.

For example, if you turn in a QR 7 in March, you will report what income you had in February. You will also report any income changes you expect to have in April, May and June. If the income from February will stay the same, your cash aid and/or CalFresh benefits for April, May, and June will be figured using that same income and expenses for each of those months. If your income and expenses will change, your worker will use the new income amounts you think you'll get in April, May, and June to figure your cash aid and/or CalFresh benefit amount for those months. This method is called prospective budgeting.

Property Limit

CalWORKS:

There is a $2000 limit on the value of the property (e.g. bank accounts, stocks, etc.) that your family can own and be eligible to receive CalWORKs benefits. If someone in your family is at least 60 years of age the limit is $3000. Your residence and furniture are not part of the limit. You may own a vehicle worth up to $4650. If your registered vehicle is worth more than $4650, any value over that limit will count as part of your property limit unless the vehicle is used by your family for certain special reasons. Ask your worker what those reasons are. Any vehicle you have, that cannot be sold for more than $1500, will not count towards your property limit. Your worker can explain to you how to figure the value of any vehicle.

CalFresh:

If you only get CalFresh benefits and do not get cash aid there is no property limit. For recipients who get both cash aid and CalFresh benefits, the CalWORKs property limits (above) will apply.

CASH AID ONLY
48-Month Time Limit

As of July 1, 2011 a parent or caretaker relative is not eligible for cash aid when he/she has received cash aid for a total of 48 months. All cash aid received from CalWORKs and/or cash aid received from Tribal TANF or any other state counts toward the 48-month total. Only cash aid received on or after January 1, 1998 counts toward the 48-month total. There are exceptions to this time limit and the limit does not apply to children.

Resources/Electronic Benefits Transfer (EBT)

Any balance remaining in the EBT account at the end of the month will be considered an available resource and could make your household ineligible for cash aid if your total countable resources are more than the allowable resource limits.

Transfer of Assets Rule

Recipients can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the family will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number.

CALFRESH ONLY
Utility Allowances

You will be allowed a Standard Utility Allowance (SUA) deduction if you have heating and cooling costs. If you have utility costs other than heating or cooling, such as water, sewer and garbage, you will be given a Limited Utility Allowance (LUA) deduction. If you only have a telephone cost, you will be given a Telephone Utility Allowance (TUA) deduction. The SUA, LUA and TUA are used to reduce your income, which helps you get more benefits.

MEDI-CAL/34-COUNTY CMSP ONLY
Spending Down Excess Property

- If you get or apply for Medi-Cal/34-County CMSP Only and you have more property than the rules allow, you may lower it by the last day of any month, including the month of application. For Medi-Cal you may spend your excess property in any manner you want. But you may not be eligible for nursing facility level of care for a period of time if you sell or give away any property for less than its worth, and you apply for or receive Medi-Cal nursing facility level of care within 30 months of the transfer.
- You may not be eligible for 34-County CMSP if you sell or give away any property for less than it is worth.

Resources And Property

- All Medi-Cal benefits received after age 55 are subject to recovery from a deceased Medi-Cal recipient's estate. However, recovery may not exceed the value of the estate. Recovery may not occur if the beneficiary is survived by a spouse. The state may not claim the proportionate share of an estate left to a minor child or a totally disabled adult child. In addition if recovery would cause an undue hardship for any other heirs and that hardship can be demonstrated, recovery may be waived in full or in part.
- If you are institutionalized and your home or former home is not exempt, the state may record a lien against your property to repay the cost of medical care covered by Medi-Cal.

AVAILABLE SERVICES

Women, Infants and Children (WIC) Supplemental Nutrition Program: The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

Voter Registration: If you want to register to vote, ask your worker to send you a registration form. If you need help filling it out, ask your worker. You can mail the form yourself. Your eligibility for aid will not be affected whether or not you register. Your worker will not tell you how to vote.

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than $400 is wrongly paid out for cash aid, CalFresh benefits, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or CalFresh benefits.

Disqualification Penalties

Cash Aid and CalFresh

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or CalFresh overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to $10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

CalFresh Only

If your household receives CalFresh benefits, it must follow these rules:

- **Don't give wrong or incomplete facts to get or keep getting CalFresh benefits.**
- **Don't trade or sell your EBT card.**
- **Don't alter your EBT card to get CalFresh benefits you are not entitled to get.**
- **Don't use CalFresh benefits to buy ineligible items such as alcoholic drinks, tobacco, paper, or cleaning products.**
- **Don't use someone else's EBT card for your household.**

CalFresh Penalties

If you do not follow CalFresh rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- **you traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation;**
- **you traded or sold CalFresh benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;**
- **you traded or sold CalFresh benefits that were worth $500 or more, your CalFresh benefits can be stopped forever;**
- **you filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, your CalFresh benefits can be stopped for 10 years.**

APPLICANT/RECIPIENT CERTIFICATION

- I understand that one of the intended purposes for the cash aid is to help meet the basic needs of my family, including housing, food, clothing.
- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or CalFresh, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A QR).
- I also certify that, if I applied for or get cash aid, I got a copy of the following:
  - ☐ Welfare to Work Informing Notice (WTW 5)

  (APPLICANT/RECIPIENT'S INITIALS) _____
- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219 /CMSP 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or CalFresh, and/or share of cost for Medi-Cal/34-County CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A QR)
- For cash aid:
  - ☐ Welfare to Work Informing Notice (WTW 5)
- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, CalFresh Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home, Registered Domestic Partner)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than $400 is wrongly paid out for cash aid, CalFresh benefits, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or CalFresh benefits.

Disqualification Penalties

Cash Aid and CalFresh

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or CalFresh overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to $10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

CalFresh Only

If your household receives CalFresh benefits, it must follow these rules:

- **Don't give wrong or incomplete facts to get or keep getting CalFresh benefits.**
- **Don't trade or sell your EBT card.**
- **Don't alter your EBT card to get CalFresh benefits you are not entitled to get.**
- **Don't use CalFresh benefits to buy ineligible items such as alcoholic drinks, tobacco, paper, or cleaning products.**
- **Don't use someone else's EBT card for your household.**

CalFresh Penalties

If you do not follow CalFresh rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- **you traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation;**
- **you traded or sold CalFresh benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;**
- **you traded or sold CalFresh benefits that were worth $500 or more, your CalFresh benefits can be stopped forever;**
- **you filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, your CalFresh benefits can be stopped for 10 years.**

APPLICANT/RECIPIENT CERTIFICATION

- I understand that one of the intended purposes for the cash aid is to help meet the basic needs of my family, including housing, food, clothing.
- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or CalFresh, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A QR).
- I also certify that, if I applied for or get cash aid, I got a copy of the following:
  - ☐ Welfare to Work Informing Notice (WTW 5)

  _____
  (APPLICANT/RECIPIENT'S INITIALS)
- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219 /CMSP 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or CalFresh, and/or share of cost for Medi-Cal/34-County CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A QR)
- For cash aid:
  - ☐ Welfare to Work Informing Notice (WTW 5)
- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, CalFresh Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home, Registered Domestic Partner)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date

"New" Form

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH CARE SERVICES

RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

For the Cash Aid and CalFresh Programs, and/or Medi-Cal/34-County Medical Services Program (CMSP)

These pages give you your rights and responsibilities and other important information. The county needs your facts to see if you are eligible for cash aid, CalFresh benefits, and/or Medi-Cal/34-County CMSP and to figure how much you will get if you are eligible. If you need more information or have questions, ask your worker.

Cash Aid includes California Work Opportunity and Responsibility to Kids (CalWORKs) and Refugee Cash Assistance (RCA).

Medi-Cal/34-County CMSP includes Full Medi-Cal/34-County CMSP benefits and Restricted Medi-Cal/34-County CMSP emergency and pregnancy related care only.

YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel you have been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

   State Civil Rights Bureau
   744 P Street, MS 8-16-70
   P.O. Box 944243
   Sacramento, CA 94244-2430

   or by calling toll free 1-866-741-6241 or for the hearing impaired TDD 1-800-688-4486.
2. To get help applying for or continuing to receive cash aid, benefits and services if you have a disability. If you need help because of a disability, tell the county.
3. To ask for help to complete your application or any other cash aid, CalFresh, or Medi-Cal/34-County CMSP form.
4. To ask for an interpreter and to have forms and notices translated if you don't speak or read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have your eligibility determined within 45 days for cash aid and Medi-Cal/34-County CMSP (or 90 days for Medi-Cal if a determination of disability is required) and within 30 days for CalFresh benefits.
7. To discuss your case with the county and to review your case yourself when you request to do so.
8. To be told the rules for getting cash aid right away. If we think you might be eligible, you will get an interview within one day.
9. To be told the rules for getting CalFresh benefits right away. If we think you might be eligible to get them right away, you will get an interview immediately and get CalFresh benefits within three days.
10. To get Medi-Cal/34-County CMSP as soon as possible if you have a medical emergency or are pregnant, if eligible.
11. To continue getting cash aid and Medi-Cal benefits without a break if you move from one county to another if you stay eligible.
12. To be told the rules for retroactive Medi-Cal eligibility.
13. To lower any current Share of Cost you may have by giving the county past unpaid medical bills you still owe, when you apply for Medi-Cal.
14. To choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when eligible for Medi-Cal.
15. To ask to have your Medi-Cal Benefits Identification Card (BIC), or EBT card replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible.
16. To ask for extra money if your income drops or stops (cash aid only).
17. To ask for payments for clothing, housing or essential household items which are lost, damaged or otherwise unavailable due to sudden and unusual circumstances (cash aid only).
18. To ask for payments for ongoing special needs like a special diet, transportation for ongoing medical care, special laundry service, telephone for the hard of hearing, high utility bills, etc. (cash aid only).
19. To be notified in writing when your application is approved, denied, or when your benefits change or stop.
20. To have your records kept confidential by the county and state, unless you are getting cash aid or CalFresh benefits and there is a felony arrest warrant issued for you, or as otherwise provided by law.
21. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
22. To ask for a State Hearing within 90 days of the county's action for cash aid, CalFresh and Medi-Cal.
23. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 21 above.
24. To be represented at a State Hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.
25. To have reasonable access to a location where you can withdraw your cash benefits with minimal or no costs.
26. To get a brochure that will tell you how to use your EBT card and how to get your cash benefits at minimal or no costs.
27. To get a list of surcharge-free ATMs and stores where you can get cash back at no cost when you make a purchase with your EBT card. You can get a list of these locations from your county worker or at www.ebt.ca.gov.

YOUR RESPONSIBILITIES

Citizenship/Immigration Status

To sign under penalty of perjury that each person applying for cash aid and CalFresh benefits is a U.S. citizen, U.S. national, or has lawful immigration status. We will check the immigration status information with the U.S. Citizenship and Immigration Services (USCIS) to make sure the person is eligible. For CalFresh, if there are people in your home who are not applying for CalFresh benefits, you do not have to provide their citizenship or immigration status.

If you want Medi-Cal/34-County CMSP, you must provide a declaration of citizenship/immigration status under penalty of perjury. If you say you are a noncitizen with lawful permanent residence (LPR) in the U.S., an amnesty alien with a valid and current I-688 or a noncitizen permanently residing under color of law (PRUCOL), your immigration status will be checked with the USCIS. The information the USCIS gets to verify the immigration status of the applicant can only be used to determine Medi-Cal/34-County CMSP eligibility, and cannot be used for immigration enforcement, unless you are committing fraud.

Fingerprint/Photo Imaging

All eligible adult household members for cash aid, and any adult applying for a child-only grant, must be fingerprint/photo imaged. If you are required to meet this rule but do not get fingerprint/photo imaged, the entire household will not get cash aid benefits. (Manual of Policies and Procedures (MPP) Section 40-105.3.)

The fingerprint/photo images are confidential. We can only use them to prevent fraud or to bring a criminal case against you for welfare fraud.

Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for cash aid, CalFresh and Medi-Cal/34-County CMSP may result in repayment of benefits and/or criminal or civil action.

Cash Aid and CalFresh Benefits: You must give us the SSN for each applicant or recipient of cash aid and/or CalFresh. If you refuse to give us either a SSN or proof of application for a SSN, you will not be able to get cash aid or CalFresh benefits. For CalFresh, if there are people in your home who are not applying for CalFresh benefits, you do not have to provide their SSN. For cash aid, you must give proof of application for a SSN within 30 days of application for cash aid and give the SSN to the county when you get it. (MPP Section 40-105.2).

Each applicant for Medi-Cal/34-County CMSP, who says he/she is a U.S. citizen, a U.S. national, LPR in the U.S., an amnesty alien with a valid and current I-688, or PRUCOL, will be disqualified from getting Medi-Cal if he/she refuses to give either a SSN or proof of application for a SSN. Any noncitizen who does not have a SSN and who is not an amnesty alien with a valid and current I-688 or a LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

Verification(s)

To give proof to support your eligibility. If you can't get proof, we will help you get it. You may need to sign a release for third party information or sign a sworn statement. (MPP Sections 40-105.1; 40-157.212; 40-157.213)

Cooperation

To cooperate with county, state and federal staff. For cash aid, a county worker can come to your home at an arranged time to check out your facts, including seeing each family member. You may not get benefits or your benefits may be stopped if you don't cooperate.

CASH AID AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, Social Security or Medicare, etc.

Child/Spousal and Medical Support

To cooperate with the county and the Local Child Support Agency to:

- identify and locate any absent parent in your case;
- tell the county or the Local Child Support Agency anytime you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- get medical support money from any absent parent and, if you get cash aid, get child support money;
- give the Local Child Support Agency any medical support money and, any child/spousal support money you get;
- tell the county about medical coverage or money for medical services paid by the absent parent.

Your cash aid will be lowered if you fail to cooperate without a good reason. (MPP Sections 40-157.212; 40-157.213).

MEDI-CAL

Benefits Identification Card (BIC)

- To sign your BIC when you get it and to use it only to get necessary health care services.
- **To never throw your BIC away** (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
- To take the BIC to your medical provider when you or a family member is sick or has an appointment.
- To take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.

Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance you or a family member have.
- To keep any health insurance available to you and your family at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans you have before using Medi-Cal/34-County CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.
- To enroll and stay enrolled in an employment-related group health plan when Medi-Cal approves payment of plan premiums by the State of California.

YOUR REPORTING RESPONSIBILITIES

You must report certain information to the county. If you're not sure how to report, what to report, or what proof we need, ask your worker. If you get CalFresh benefits, your worker will tell you if you are a semi-annual or change reporting household. If you get Medi-Cal/34-County CMSP, the county will tell you when you must report. (MPP Section 40-181).

HOW YOU MUST REPORT

For Cash Aid and CalFresh Semi-Annual Reporting, in addition to your annual SAWS 2 you must turn in a Semi-Annual Eligibility Report (SAR 7) by the fifth day of the month following your report month and report all required changes to the county within 10 days.

For CalFresh Change Reporting, you must report all changes within 10 days:

- by mail, telephone, or in person at the county CalFresh office; OR
- on the SAR 3 or AR 3; OR
- on a DFA 377.5, CalFresh Household Change Report

For Medi-Cal, you must report all changes within 10 days AND turn in a complete Status Report by the 5th of the month when the county sends or gives it to you.

WHEN YOU MUST REPORT

For Cash Aid and CalFresh Semi-Annual Reporting

Semi-Annual Reporting (SAR) rules say that you must report certain things two times each year. The first report will be your application or redetermination/recertification (RD/RC) on your statement of facts (SAWS 2) form. The second report will be the Semi-Annual Eligibility Report (SAR 7). The SAR 7 report is always due by the 5th day of the sixth month following your application or annual RD/RC and will be considered late if not received by the 11th day of the month. If your SAR 7 is late you will have to pay back any cash aid or CalFresh that you were not supposed to get. You will have to report gross income, as well as any changes in your gross income that you are sure will happen in the next six months, changes in the number of people in your household and information about any new household member, and any property bought or sold by people in your household. The report month will be on the top of the SAR 7 form. If you do not turn in a completed SAR 7 by the end of the first working day of the month after the month your report is due, your household's benefits will be stopped. If you turn in your complete SAR 7 at any time in the month following the month your SAR 7 is due, your household's benefits will be started again from the date you turn it in, if you are still eligible.

What you must report on the Semi-Annual Report (SAR 7):

1. **Earned Income**: All gross earned income you or anyone in your household got in the report month. This includes wages; tips; vacation pay; cash bonuses; In-Home Supportive Services (IHSS); money from self-employment or from a training program; also any income in kind you or anyone in your household got in exchange for work, such as free rent, clothing or food.
2. **Unearned or Disability Based Income:** All other income you or anyone in your household got in the report month. This includes child/spousal support; interest or dividends; gambling/lottery winnings; insurance or legal settlements; strike benefits; cash, gifts, loans scholarships; tax refunds; any government benefits, like Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), unemployment, worker's compensation, state disability indemnity (SDI), veterans or railroad retirement, or other private or government disability or retirement; rental income and rental assistance; free housing/utilities/clothing/food; or any other type of money you or anyone in your household got. You must also report on your SAR 7 any changes in income that you are sure will happen during the next six months. This includes earned, unearned and disability based income changes.
3. **Property:** Any property including: motor vehicles; bank accounts; savings bonds; insurance policies; a home or land; trust; EBT cash balance, etc. that you or anyone in your household has gotten since you last reported and still has, whether it was bought, gotten through a trade or as a gift. The county will use this information to decide if your household exceeds the property limit. You must also report if you or anyone sold, traded or gave away any property since you last reported.
4. **If You Move or Someone Moves Into or Out of Your Home:** Anyone (including newborns) who moved into your home since you last reported and is still there. You must also report anyone who moved out of your home or who has died since you last reported.
5. **Convicted Drug Felons, Fleeing Felons and Probation/ Parole Violators:** The name of anyone in your household who is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime. The name of anyone in your household who has been found by a court of law to be in violation of probation or parole. You must also report any household member who has been convicted of a drug felony for possession, use, manufacturing, sale, or distribution, of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in these activities. For CalFresh you must report felonies that happened since August 22, 1996 and for cash aid list convictions that happened after January 1, 1998.
6. **Reduced Hours of Work:** If you are between 19 and 50 and you are not caring for minor children, you must report when your hours of work drop below 20 hours a week or 80 hours a month. You must also report if you know your work hours will drop below these limits during the next six months.

For Medi-Cal/34-County CMSP, you must report when:

1. Anyone enters or leaves a nursing home or long term care facility.
2. Anyone applies for disability benefits, such as SSI/SSP, Social Security, Veterans, or Railroad Retirement.
3. Anyone gets health care services that result from an accident or injury due to someone else's action or failure to act.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

For Non-Assistance CalFresh Semi-Annual Reporting

If you only get CalFresh benefits you must report when:

1. Anytime that your household's total gross monthly income is more than the Income Reporting Threshold (IRT) for your household size. Your IRT is 130% of the Federal Poverty level for your household size. The county will tell you your IRT.
2. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

For CalWORKs you must report certain changes at other times:

In certain circumstances you will be required to report things (within ten days of the change) even if it is not your "report month" such as:

1. Anytime that your family's combined gross income (both earned and unearned) is more than the Income Reporting Threshold (IRT) for your family. The county will tell you your IRT. If your family only gets unearned income, you will only be required to report income on your Semi-Annual Eligibility Report (SAR 7) and your annual RD/RC (SAWS 2).
2. Anytime that someone in your household is convicted of a drug related felony, becomes a fleeing felon or is found by a court to be in violation of probation or parole.
3. Anytime you move you must report your address change so that the county will know where to send your SAR 7 and other notices.

Reporting information voluntarily for CalWORKs and CalFresh Semi-Annual Reporting:

You may also report other information voluntarily even when it is not your "report month." Reporting information voluntarily may cause your household's benefits to go up. If the information reported causes your benefits to go up, the county will take action within ten days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the county will take action to increase benefits the first of the month after you provide verification.

Some examples of voluntary reporting that may cause your benefits to go up include:

- Your income stops or drops.
- Someone who has little or no income moves into your home (including a newborn).
- Someone who has income moves out of your home.
- You believe that you or someone in your household is eligible for a CalWORKs Special Needs payment, such as pregnancy special needs or a qualifying special diet.

Additional examples for CalFresh only:

- A household member begins to pay court ordered child support for a child not living in the home.
- A household member is 60 or older.
- Any member who is disabled or 60 years of age or older has changes in or new medical expenses (if verified your CalFresh can be refigured).

At anytime you can ask the county to discontinue your entire case or any individual person who has left the home or is not required to be in the assistance unit. You can also ask the county to discontinue certain benefits, such as: Medi-Cal or CalFresh. Receiving Medi-Cal/or CalFresh only will not count against your cash aid time limits.

Additional Information for CalFresh Only Households

If you receive only CalFresh benefits and you voluntarily report that someone has moved into or out of your home, the county will act on that change even if it results in a decrease to your CalFresh benefits.

Other changes for Semi-Annual Reporting:

There are other changes that will cause the county to decrease or discontinue your benefits during the period in which they happen. Here are some examples:

- An adult in the household reaches the CalWORKs 48-month time limit;
- A household member is sanctioned/penalized;
- A child reaches the age of 18 (and will not graduate from high school before the age of 19);
- Someone in your household begins receiving benefits in another household;
- An eligible child is placed in Foster Care;
- Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

CALFRESH CHANGE REPORTING

For CalFresh Change Reporting, you must report when:

1. Your total monthly income starts, stops, or changes by more than $50.
2. Anyone's source of income changes.
3. Anyone moves into or out of your home.
4. Anyone joins or leaves your household.
5. You move or you get a new address.
6. Your rent and utility costs **only** if you move.
7. If there is a change in the amount of any court ordered child support paid by a member of the household for a child not living in the home.
8. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.
9. Any member of your household is avoiding or running from the law to avoid any felony prosecution, custody or confinement after conviction, or is found by a court to be in violation of probation or parole.
10. Any household member convicted of a drug-related felony after August 22, 1996, for manufacturing, sale or distribution of a controlled substance(s), or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities.

For CalFresh Change Reporting, you may report when:

1. Anyone's physical or mental illness begins or ends.
2. Anyone's citizenship/immigration status changes or anyone gets a letter, form or new card from the USCIS.
3. You have changes in your dependent care costs.
4. Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.
5. Any household member starts to pay court ordered child support for a child not living in the home.

CalWORKs Annual Reporting for Certain Child-Only Cases (AR/CO)

Most CalWORKs cases where only the children get cash aid will only have to report once each year except for a few mandatory changes that must be reported within 10 days of when they happen. These cases are called Annual Reporting/Child-Only (AR/CO) cases. The County will tell you if you have an AR/CO case.

AR/CO cases will only have to report changes at their Annual RD, with the following exceptions:

- Anytime your family's combined gross income, both earned and unearned is more than the Income Reporting Threshold (IRT) for your family. The County will tell you in writing what your IRT is.
- Anytime someone moves into or out of your home. This includes newborns and children who are placed in foster care.
- Anytime you have an address change.
- Anytime that someone joins or is in your household that is convicted of a drug related felony, becomes a fleeing felon or is found by a court to be in violation of probation or parole and it was not already reported.

CalWORKs AR/CO Cases Who Receive CalFresh

CalFresh households who are part of a CalWORKs AR/CO case will report semi-annually. See Pages 3 and 4 of this notice for semi-annual reporting responsibilities.

Voluntary Reporting Information for CalWORKs AR/CO cases and CalFresh Change Reporting Households

You can also report some changes voluntarily. Reporting some changes may help your cash aid go up. See page 4 of this notice for more information about voluntary reporting.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

IMPORTANT INFORMATION CASH AID ONLY

Unemployed Parent

If you are applying for cash aid as an unemployed parent, the principal earner (PE) must:

- be unemployed and not have worked in the preceding 4 weeks
- apply for and accept any unemployment insurance you are eligible to get

The PE is the parent who has the most earnings in the past 24 months.

Homeless Assistance

You may be eligible for money to help pay for temporary shelter, permanent housing or to prevent eviction. This is a once-in-a-lifetime payment unless you meet an exemption. If you have already received homeless assistance and need it again, your worker will tell you if you are eligible.

School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children are attending school, and
- children under the age of 6 have received age appropriate immunizations. (MPP Sections 40-105.4; 40-105.5).

Maximum Aid Payment (MAP)

There are two levels of Maximum Aid Payment (MAP). Most families getting cash aid get the lower MAP level. Families may get the higher MAP level if each parent or caretaker in the Assistance Unit (AU):

- is disabled and getting Supplemental Security Income/ State Supplemental Payments (SSI/SSP), or In-Home Supportive Services (IHSS), or State Disability Insurance (SDI), or Temporary Workers Compensation (TWC), or Temporary Disability Indemnity (TDI) benefits
- is caring for an aided child(ren) who is not their child and the caretaker does not get cash aid.

Also eligible for the higher MAP:

- a family who gets Refugee Cash Assistance (RCA) if each adult meets an exception.

Maximum Family Grant (MFG) Rule

The MFG rule applies to any child born after August 31, 1997. The MFG rule says that your cash aid grant will not go up to include a child born to your family, if your family got cash aid for the 10 months in a row right before the child's birth. There are situations where the rule does not apply. Your worker will give you a copy of the MFG rules and answer your questions. Then you will sign a copy that says you understand the rules.

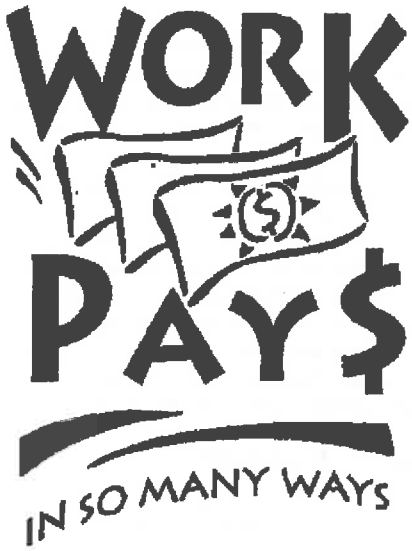
Proof of Facts

If you ask for cash aid within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for cash aid within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since you last got cash aid, the county will need new proof.



Here's how **Work Pays:**

- Gives you more $$$$ to help support your family
- Builds a better life for you and your family
- Develops job skills
- Builds self-esteem
- Gives you personal satisfaction

You can work and still get cash aid:

✔ In most cases, when you work, your gross earnings (earnings before deductions) are not subtracted dollar for dollar from your cash aid payment. You may be eligible for **work related deductions**. When you add it up, you have more $$$$ for your family.

✔ When you have a **grant-based on the job training (OJT)** assignment, all or part of your cash aid payment is used by your employer to help pay your wages. You do not get work related deductions for grant based OJT wages.

✔ Either way, you may be eligible for child care costs that are paid to your provider.

See page 8 for facts about work and training rules, work incentives, including child care programs. Ask your worker for more facts about **Work Pays** and how **grant-based OJT** can work for you.

Remember, you can work and still get cash aid as long as you stay eligible and meet reporting rules in a timely manner.

Work and Training Rules

Your worker will tell you what cash aid and/or CalFresh work rules you need to follow before and after your application is approved. You may be required to be in work, training or education activities to keep getting your cash aid, CalFresh, or both. More than one member of a household can be required to follow cash aid and/or CalFresh work rules. If anyone becomes ineligible for not following work or training rules, other members of their household can still get cash aid or CalFresh, as long as they remain eligible. But the amount of cash aid or CalFresh they get may change.

Cash Aid Work Rules

If you get cash aid and CalFresh benefits or just get cash aid, you will need to take part in certain Welfare-to-Work activities to keep getting your cash aid and CalFresh benefits. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules. Welfare-to-Work activities include, but are not limited to, subsidized or unsubsidized work, work experience, community service, adult basic education, vocational training, and job search. Subsidized means that the county or some other funding source pays your employer for part of your wages.

The cash aid work rules also say you must:

- Sign a Welfare-to-Work plan;
- Take a suitable job that is offered to you;
- Not quit a job or reduce your earnings.

Sanctions for Not Meeting Cash Aid Work Rules

Any time you don't meet cash aid work rules and you don't have a good reason, your cash aid will be stopped until you do what you should do. After your cash aid is stopped or reduced, you can only get it back again if you meet the work rules that you had stopped meeting or if you become excused. If your cash aid is stopped, your CalFresh benefits may also be stopped or reduced.

CalFresh Work Rules for Persons Not Receiving Cash Aid

If you only get CalFresh benefits, you may need to take part in certain employment and training activities to keep getting your CalFresh benefits. These activities include job search, workfare, adult basic education, and vocational training. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules.

The CalFresh work rules also say you must:

- Answer questions about your job experience and ability to work;
- Check on a possible job we tell you about and take a suitable job that is offered to you;
- Not quit a job or reduce the number of hours you work to less than 30 hours per week.

CalFresh Only Penalties

If you don't meet CalFresh work rules and you don't have a good reason, your CalFresh benefits will be denied or stopped for one, three, or six months, depending on the number of times you stop meeting the rules. After your CalFresh benefits are stopped, you can only get them again at the end of the penalty or sooner if you become exempt.

Work Requirement for Able-Bodied Adults Not Receiving Cash Aid

If you only receive CalFresh benefits and you don't have minor children, there is another work rule which you also may need to meet. You do not have to meet this work rule if you are under age 18, over age 49, pregnant, or you are part of a CalFresh household with a minor child. You may be excused for other reasons that your county worker can explain. The work rule says that if you are an able-bodied adult, you must work at least 20 hours a week or 80 hours a month in paid employment, take part in a workfare project for the required number of hours, or take part in an approved training activity for at least 20 hours per week or 80 hours per month. During a period of 36 months, CalFresh benefits will stop if there are three months in which you do not meet the work rule. If you stop meeting the work rule a second time for reasons such as being laid off, you may be able to get CalFresh benefits for three months in a row without having to meet the rule. After that you can only get CalFresh benefits if you meet the work rule or get excused.

CalWORKs Income Disregards

The total amount of cash aid your family receives is based on your family size and any other income you may have. The law allows for some income to be disregarded when the total amount of cash aid you will receive is calculated.

- If your family gets more than $225 a month of Disability Income (DI), only the first $225 is disregarded.
- If your family gets $225 a month or less of DI, none of it will be counted as income and if you also have Earned Income (EI), any remaining amount of the $225 disregard, up to $225, will not be counted as income.
- In addition, 50 percent of any other EI will be disregarded.
- The remainder is your net countable income and is the amount that will be used to figure your cash aid.

Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

CalWORKs Child Care Program

Child care benefits are available to recipients who need child care to work or participate in county-approved welfare-to-work activities such as attending education or job training programs.

California Department of Education (CDE) Child Care

Child care benefits are also available from CDE. Contact your local Resource and Referral Agency for more information.

Transitional Medi-Cal (TMC)

You may get Medi-Cal for up to 12 months if you go off cash aid because you are working. Your family must have gotten cash aid for at least three of the last six months before cash aid stopped. To get more than six months of TMC, your income must be under certain limits and you must meet TMC reporting rules.

OTHER IMPORTANT INFORMATION

CASH AID AND CALFRESH SEMI-ANNUAL REPORTING (SAR) HOUSEHOLDS
Budgeting Rules

The amount of cash aid and/or CalFresh benefits you can get depends on your income and allowable expenses. You will get a Semi-Annual Eligibility Report (SAR 7) to fill out six months after your application and after every annual redetermination/recertification (RD/RC). On the SAR 7, you will need to report what income and expenses you had in the report month and any known changes you will have in the six months after you turn in your report. The report month will be on the top of your SAR 7. The income and expenses you have in the report month and any known changes will be used to figure the amount of cash aid and/or CalFresh benefits you can get for those six months. Information that you put on the SAR 7 about the report month will be used for the next six months if you don't expect your income or expenses to change.

For example, if you turn in a SAR 7 in March, you will report what income you had in February. You will also report any income changes you expect to have in April, May, June, July, August and September. If the income from February will stay the same, your cash aid and/or CalFresh benefits for April, May, June, July, August and September will be figured using that same income and expenses for each of those months. If your income and expenses will change, your worker will use the new income amounts you'll get in those months to figure your cash aid and/or CalFresh benefit amount for each month of the semi-annual period. This method is called prospective budgeting.

CASH AID ANNUAL REPORTING (AR) CASES AND CALFRESH CHANGE REPORTING HOUSEHOLDS WITH A CALWORKS AR CASE
Budgeting Rules

Annual Reporting (AR) households will also use prospective budgeting except you will not have a regular report form like the SAR 7 for SAR households. AR households will report on their annual RD/RC forms any income, expenses and property they have and any changes they are sure will happen in the next 12 months. The information you provide will be used to figure your cash aid and CalFresh benefits for the next 12 months. There are some things that you will have to report within 10 days of when they happen. The mandatory reporting rules for AR cases and CalFresh change reporting households with an AR case are on page 5 of this form.

Property Limit

CalWORKS:

There is a $2000 limit on the value of the property (e.g. bank accounts, stocks, etc.) that your family can own and be eligible to receive CalWORKs benefits. If someone in your family is at least 60 years of age or disabled the limit is $3250. Your residence and furniture are not part of the limit. You may own a vehicle worth up to $4650. If your registered vehicle is worth more than $4650, any value over that limit will count as part of your property limit unless the vehicle is used by your family for certain special reasons. Ask your worker what those reasons are. Any vehicle you have, that cannot be sold for more than $1500, will not count towards your property limit. Your worker can explain to you how to figure the value of any vehicle.

CalFresh:

For recipients who get both cash aid and CalFresh benefits the CalWORKs property limits (above) will apply. If you only get CalFresh benefits, the property limit for households without an elderly or disabled member is $2000. The property limit for households with at least one member who is age 60 or older or disabled is $3250.

The property limits may not apply if your household's gross income is not more than the CalFesh Income Reporting Threshold (IRT) for your household size. Your CalFresh IRT is 130 percent of the Federal Poverty Limit for your household size. The county will tell you the amount of your household's IRT.

CASH AID ONLY
48-Month Time Limit

As of July 1, 2011 a parent or caretaker relative is not eligible for cash aid when he/she has received cash aid for a total of 48 months. All cash aid received from CalWORKs and/or cash aid received from Tribal TANF or any other state counts toward the 48-month total. Only cash aid received on or after January 1, 1998 counts toward the 48-month total. There are exceptions to this time limit and the limit does not apply to children.

Resources/Electronic Benefits Transfer (EBT)

Any balance remaining in the EBT account at the end of the month will be considered an available resource and could make your household ineligible for cash aid if your total countable resources are more than the allowable resource limits.

Transfer of Assets Rule

Recipients can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the family will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number.

CALFRESH ONLY
Utility Allowances

You will be allowed a Standard Utility Allowance (SUA) deduction if you have heating and cooling costs. If you have utility costs other than heating or cooling, such as water, sewer and garbage, you will be given a Limited Utility Allowance (LUA) deduction. If you only have a telephone cost, you will be given a Telephone Utility Allowance (TUA) deduction. The SUA, LUA and TUA are used to reduce your income, which helps you get more benefits.

MEDI-CAL/34-COUNTY CMSP ONLY
Spending Down Excess Property

- If you get or apply for Medi-Cal/34-County CMSP Only and you have more property than the rules allow, you may lower it by the last day of any month, including the month of application. For Medi-Cal you may spend your excess property in any manner you want. But you may not be eligible for nursing facility level of care for a period of time if you sell or give away any property for less than its worth, and you apply for or receive Medi-Cal nursing facility level of care within 30 months of the transfer.
- You may not be eligible for 34-County CMSP if you sell or give away any property for less than it is worth.

Resources And Property

- All Medi-Cal benefits received after age 55 are subject to recovery from a deceased Medi-Cal recipient's estate. However, recovery may not exceed the value of the estate. Recovery may not occur if the beneficiary is survived by a spouse. The state may not claim the proportionate share of an estate left to a minor child or a totally disabled adult child. In addition if recovery would cause an undue hardship for any other heirs and that hardship can be demonstrated, recovery may be waived in full or in part.
- If you are institutionalized and your home or former home is not exempt, the state may record a lien against your property to repay the cost of medical care covered by Medi-Cal.

AVAILABLE SERVICES

Women, Infants and Children (WIC) Supplemental Nutrition Program: The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

Voter Registration: If you want to register to vote, ask your worker to send you a registration form. If you need help filling it out, ask your worker. You can mail the form yourself. Your eligibility for aid will not be affected whether or not you register. Your worker will not tell you how to vote.

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than $950 is wrongly paid out for cash aid, CalFresh benefits, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or CalFresh benefits.

Disqualification Penalties

Cash Aid and CalFresh

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or CalFresh overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to $10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

CalFresh Only

If your household receives CalFresh benefits, it must follow these rules:

- **Don't give wrong or incomplete facts to get or keep getting CalFresh benefits.**
- **Don't trade or sell your EBT card.**
- **Don't alter your EBT card to get CalFresh benefits you are not entitled to get.**
- **Don't use CalFresh benefits to buy ineligible items such as alcoholic drinks, tobacco, paper, or cleaning products.**
- **Don't use someone else's EBT card for your household.**

CalFresh Penalties

If you do not follow CalFresh rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- **you traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation;**
- **you traded or sold CalFresh benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;**
- **you traded or sold CalFresh benefits that were worth $500 or more, your CalFresh benefits can be stopped forever;**
- **you filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, your CalFresh benefits can be stopped for 10 years.**

APPLICANT/RECIPIENT CERTIFICATION

- I understand that one of the intended purposes for the cash aid is to help meet the basic needs of my family, including housing, food, clothing.
- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or CalFresh, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A).
- I also certify that, if I applied for or get cash aid, I got a copy of the following:
  - ☐ Welfare to Work Informing Notice (WTW 5)

  _____
  (APPLICANT/RECIPIENT'S INITIALS)
- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219 /CMSP 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or CalFresh, and/or share of cost for Medi-Cal/34-County CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A)
- For cash aid:
  - ☐ Welfare to Work Informing Notice (WTW 5)
- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, CalFresh Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home, Registered Domestic Partner)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than $950 is wrongly paid out for cash aid, CalFresh benefits, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or CalFresh benefits.

Disqualification Penalties

Cash Aid and CalFresh

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or CalFresh overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to $10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

CalFresh Only

If your household receives CalFresh benefits, it must follow these rules:

- **Don't give wrong or incomplete facts to get or keep getting CalFresh benefits.**
- **Don't trade or sell your EBT card.**
- **Don't alter your EBT card to get CalFresh benefits you are not entitled to get.**
- **Don't use CalFresh benefits to buy ineligible items such as alcoholic drinks, tobacco, paper, or cleaning products.**
- **Don't use someone else's EBT card for your household.**

CalFresh Penalties

If you do not follow CalFresh rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- **you traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation;**
- **you traded or sold CalFresh benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;**
- **you traded or sold CalFresh benefits that were worth $500 or more, your CalFresh benefits can be stopped forever;**
- **you filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, your CalFresh benefits can be stopped for 10 years.**

APPLICANT/RECIPIENT CERTIFICATION

- I understand that one of the intended purposes for the cash aid is to help meet the basic needs of my family, including housing, food, clothing.
- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or CalFresh, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A).
- I also certify that, if I applied for or get cash aid, I got a copy of the following:
  - ☐ Welfare to Work Informing Notice (WTW 5)

  _____
  (APPLICANT/RECIPIENT'S INITIALS)
- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219 /CMSP 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or CalFresh, and/or share of cost for Medi-Cal/34-County CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A)
- For cash aid:
  - ☐ Welfare to Work Informing Notice (WTW 5)
- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, CalFresh Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home, Registered Domestic Partner)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IMPORTANT INFORMATION - PLEASE READ
NEW REPORTING REQUIREMENTS FOR CalWORKs AND FOOD STAMP RECIPIENTS

The State of California is changing the way you report things that affect your eligibility for Cash Aid and Food Stamps. Instead of reporting changes every month, you will now have to report most changes every three months.

You will be assigned a "report month" for each quarter (three months). This is the second month of each quarter. For example, if your quarter is January, February and March, February is your "report month" and your quarterly report is due by the 5th day of March.

FOR EXAMPLE:

If your quarter begins in	Your "Report Month" is	Your QR 7 is Due by the 5th of
January	February	March
April	May	June
July	August	September
October	November	December

The Quarterly Report (QR 7) is always due by the 5th day of the month following your "report month" and will be considered late if not received by the 11th day of the month. If your Quarterly Report (QR 7) is late, you may be overpaid. If you are overpaid, you will have to pay back any Cash Aid or Food Stamp benefits that you were not supposed to get.

For your report to be complete, you must answer all the questions, sign and date it after the last day of your report month and attach proof if the form asks for it. If you do not turn in a completed QR 7 by the end of the first working day of the month after your report is due, your household's Cash Aid and/or Food Stamps will be stopped.

What you must report on the Quarterly Report (QR 7):

Earned Income:
All gross income received in the report month by you or anyone in your household. This includes wages; tips; vacation pay; cash bonuses; money from self employment or from a training program; also any work done in exchange for free rent, clothing or food.

Unearned or Disability Based Income:
All other income received in the report month by you or anyone in your household. This includes child/spousal support; interest or dividends; gambling/lottery winnings; insurance or legal settlements; strike benefits; cash, gifts, loans, scholarships; tax refunds; any government benefits, like Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), unemployment, worker's compensation, state disability indemnity, veterans or railroad retirement, or other private or government disability or retirement; rental income and rental assistance; free housing/utilities/clothing/food; or any other type of money received.
You must also report on your Quarterly Report any changes in income that you expect to happen during the next quarter (three months). This includes earned, unearned and disability based income changes.

Property:
Any property including, motor vehicles; bank accounts; savings bonds; insurance policies; a home or land; trust; EBT cash balance, etc. that you or anyone in your household has received since your last Quarterly Report and still has, whether it was bought, obtained through a trade or as a gift. The county will use this information to determine if your household exceeds the property limit. You must also report if you or anyone sold, traded or gave away any property since your last Quarterly Report.

You move or someone moves into or out of your home:
Anyone (including newborns) who moved into your home since your last Quarterly Report and is still there. You must also report anyone who moved out of your home or who has died since your last Quarterly Report.

Someone becomes pregnant:
Anyone (including minor children) who becomes pregnant since your last Quarterly Report. Pregnant members in your home may be eligible for a pregnancy special needs payment. Also, if your minor child has not completed high school or its equivalent and becomes pregnant, she may be eligible for additional services under the Cal-Learn Program.

Convicted Drug Felons, Fleeing Felons and Probation/Parole Violators:
The name of anyone in your household who is either avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole. You must also report anyone in your household who has been convicted of a drug-related felony for possession, use or distribution of a controlled substance(s). Once you have reported this information on your Quarterly Report, you do not need to report this information about the same person every quarter.

Reduced hours of work:
If you are an Able-Bodied Adult Without Dependents (ABAWD) Food Stamp recipient, you must report when your hours of work or training drop below 20 hours a week or 80 hours a month. You must also report if you expect your work or training hours to drop below these limits during the next three months.

Other things that happened since your last report.
Some other things that you will need to report include, Job/Training (started, stopped, quit, refused a job or training, the number of hours worked or in training went up or down, or went out on strike); Citizenship/Immigration Status (a citizenship or immigration status change or anyone got a new card, form or letter from the INS); Babies (became pregnant, had a baby, aborted or miscarried); Marital status (married, divorced or separated); Disability (became disabled or recovered from a disability/major illness); Insurance (started, stopped, or changed life, dental or health insurance benefits including MEDICARE coverage); IHSS (started or stopped getting In-Home Supportive Services); School-Ages 6 through 17 **(For Cash Aid Only:** stopped or started attending school regularly); School-Age 16 or older (started or stopped school or college. Cost of tuition, school transportation, etc.).

Changes you must report at other times:

There are times that you must report changes (within ten (10) days of the change) even if it is not your "report month" such as:

- If you receive Cash Aid, you must report anytime that your family's combined gross income (both earned and unearned) is more than the Income Reporting Threshold (IRT) for a family of your size. Your county worker will tell you the IRT for a family of your size. **Families that only have unearned income or that only get Food Stamps will not be required to report income except on the Quarterly Report form.**
- If you receive Cash Aid, you must report anytime that someone in your household is convicted of a drug related felony for possession, use or distribution of a controlled substance(s), becomes a fleeing felon or is in violation of a condition of probation or parole.
- If you receive Cash Aid and/or Food Stamps, you must report your address change so that the County will know where to send your benefits, Quarterly Report forms and notices.
- If you are an Able Bodied Adult Without Dependents (ABAWD) Food Stamp recipient, you must report anytime the number of hours you work or are in training drop to less than 20 hours a week or 80 hours a month.

Some information you are required to report will cause your benefits to go down or stop (such as having too much income or convicted drug felons and fleeing felons or probation/parole violators).

Changes you may report:

You can also report other information voluntarily even when it is not your "report month." Reporting information voluntarily may cause your household's benefits to go up. If the information voluntarily reported causes your benefits to go up, the county will take action within ten days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the County will take action to increase benefits the first of the month after you provide verification. **Even if you have already voluntarily reported something to the County, you must also report it on your next Quarterly Report (QR 7).**

Some examples of voluntary reporting that may cause some of your benefits to go up include:

- Someone who has no income moves into your home (including a newborn).
- Someone (including minor children) becomes pregnant.
- Someone who has income moves out of your home.
- You believe that you or someone in your household is eligible for a CalWORKs Special Needs payment, such as pregnancy special needs or a qualifying special diet.
- Someone in your household is disabled or aged 60 or older and reports **new** medical expenses that you would like to use to figure your Food Stamp benefits.

If the change you report will cause any of your benefits to go down, it will happen in the new quarter.

At anytime, you can ask the County to discontinue your entire case or any individual person who has left the home or is not required to be in the assistance unit. You can also ask the County to stop certain benefits, such as: Medi-Cal or Food Stamps. Receiving Medi-Cal and/or Food Stamps only will not count against your Cash Aid time limits.

Other changes that will cause the County to lower or stop your benefits during the quarter in which they happen.
Here are some examples:

- An adult in the household reaches the CalWORKs 60-month time limit;
- A household member is sanctioned/penalized;
- A child (who is not pregnant or who is not a parent) reaches the age of 18 (and will not graduate from high school before the age of 19);
- Someone in your household starts getting benefits in another household;
- An eligible child is placed in Foster Care.
- An Able Bodied Adult Without Dependents (ABAWD) Food Stamp recipient's number of hours worked or training drops to less than 20 hours per week or 80 hours per month.

How the County will figure your Cash Aid and Food Stamps:

New budgeting rules

The amount of Cash Aid and/or Food Stamps you can get depends on your income and allowable expenses. The income and expenses you expect to have in the next three months will be used to figure the amount of Cash Aid and/or Food Stamps you can get for those three months. Information that you put on the QR 7 will be used to figure the amount of your Cash Aid and/or Food Stamps for the next quarter (three months).

For example, if you turn in a QR 7 in March, you will report what income you had in February. You will also report any income and expense changes you expect to have in April, May, and June. If your income and/or expenses from February are expected to stay the same, your Cash Aid and/or Food Stamps for April, May, and June will be figured using February's income and expenses. If your income and/or expenses are expected to change, your worker will use the new income and/or expense amounts you think you'll get in April, May, and June to figure your Cash Aid and/or Food Stamp amount for those months. This is called prospective budgeting.

Failure to report and/or purposely reporting false or inaccurate information:

Failure to report the required information or purposely reporting false or inaccurate information may result in your benefits being overpaid. Any overpaid benefits caused by your failure to report or purposely reporting false or inaccurate information **MUST** be repaid. You may also be subject to fraud charges/penalties if you do not report required information to the County.

"New" Form

IMPORTANT INFORMATION - PLEASE READ

New Reporting Requirements for Cash Aid and CalFresh

The county is changing from Quarterly Reporting to Semi-Annual Reporting. Below are the changes that will be coming soon. We will tell you when these new rules start.

Reporting Form

Before, you turned in a QR 7 every 3 months. **Soon you will only need to turn in a report once every 6 months.**

The 6-month report form is called the SAR 7. The other report will be your annual redetermination/recertification (RD/RC) form.

The SAR 7 is due 6 months after your annual RD/RC. It is always due on the 5th day of the month. If you do not turn in your **complete** SAR 7 by the end of the first working day of the next (7th) month, **your aid will stop.**

Example: You completed your annual RD/RC in February. Your SAR 7 will be due 6 months later, on August 5th. You have to get your completed SAR 7 to your worker no later than the first working day in September or your benefits will stop. You will lose aid unless you had a good reason for being late.

Just like with your QR 7, you must answer all the questions on the SAR 7, attach proof, sign and date it, and return it by the date listed on the report.

Changes to the Income Reporting Threshold (IRT) Rules

The IRT is the amount of total monthly income that you have to report **within 10 days**. By "total monthly income" we mean any money you get. Any time your IRT changes, the county will let you know in writing.

For Cash Aid: The amount of income that you have to report within 10 days is changing. The IRT is based on your total income and the number of people in your household. Before, we would stop your benefits if your total income was over the IRT. Under the new rules, when you report income over your IRT, the county may lower **or** stop your benefits.

Example: If your IRT is $900 and you get income of $800 you do not have to report the change until your next report is due. If you get income of $901 or more you must report it to your worker within 10 days. Your benefits will go down and your worker will give you a new IRT.

For CalFresh: Before, you did not have an IRT. Soon you will have an IRT based on your household size. When you report income over your IRT, the county may stop your benefits.

Other Mandatory and Voluntary Reporting Rules are the same.

Voluntary reports may increase your benefits.