

September 11, 2020

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 20-16**

This letter informs County Welfare Departments (CWDs) of two new recommended CalFresh forms, the *Drug Addiction or Alcoholic Treatment and Rehabilitation Centers and Group Living Arrangements: Periodic Resident Report* ([CF 377.5A](#)) and the *Drug Addiction or Alcoholic Treatment Centers and Group Living Arrangements: Change Report for Residents* ([CF 377.5B](#)). These new forms aim to ensure consistency across CWDs in complying with the guidance outlined in [All County Letter \(ACL\) No. 19-51](#) regarding CalFresh eligibility for residents of institutions.



KIM JOHNSON  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



GAVIN NEWSOM  
GOVERNOR

September 11, 2020

ALL COUNTY LETTER (ACL) NO. 20-16

TO: ALL COUNTY WELFARE DIRECTORS  
ALL CALFRESH PROGRAM SPECIALISTS  
ALL CALWORKS PROGRAM SPECIALISTS  
ALL CONSORTIA PROJECT MANAGERS  
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: **CALFRESH RESIDENT REPORT AND CHANGE REPORT FORMS  
FOR RESIDENTS OF INSTITUTIONS**

REFERENCE: [FEDERAL REGISTER \(FINAL RULE\): SUPPLEMENTAL  
NUTRITION ASSISTANCE PROGRAM \(SNAP\): ELIGIBILITY,  
CERTIFICATION, AND EMPLOYMENT AND TRAINING  
PROVISIONS OF THE FOOD, CONSERVATION AND ENERGY  
ACT OF 2008, 7 CFR § 273.11\(e\)\(6\), 7 CFR § 273.11\(f\), MANUAL  
OF POLICIES AND PROCEDURES \(MPP\) 63-503.481, ACL No. 19-  
51](#)

This letter informs County Welfare Departments (CWDs) of two new recommended CalFresh forms, *Drug Addiction or Alcoholic Treatment and Rehabilitation Centers and Group Living Arrangements: Periodic Resident Report* ([CF 377.5A](#)) and *Drug Addiction or Alcoholic Treatment Centers and Group Living Arrangements: Change Report For Departing Residents* ([CF 377.5B](#)). These new forms aim to ensure consistency across CWDs in complying with the guidance outlined in [All County Letter \(ACL\) No. 19-51](#) dated May 23, 2019, regarding CalFresh eligibility for residents of institutions.

### **Background**

The California Department of Social Services (CDSS) released [ACL No. 19-51](#) which provides guidance for the Final Rule released by the Food & Nutrition Service (FNS) on February 19, 2019, that amends federal Supplemental Nutrition Assistance Program (SNAP) regulations related to Drug Addiction or Alcoholic Treatment and Rehabilitation

Centers (DAA Treatment Centers) and Group Living Arrangements (GLAs). The Final Rule was effective on April 22, 2019.

The CDSS created the [CF 377.5A](#) and the [CF 377.5B](#) to better equip CWDs with the necessary forms in order to comply with the guidance in [ACL No. 19-51](#).

**Drug Addiction or Alcoholic Treatment and Rehabilitation Centers and Group Living Arrangements: Periodic Resident Report (CF 377.5A)**

As stated in [ACL No. 19-51](#), a DAA Treatment Center and GLA must provide the CWD with a list of residents receiving CalFresh as well as a statement signed by a responsible facility official attesting to the validity of the list. For DAA Treatment Centers, the CWD must require submission of the resident list on a monthly or semi-monthly basis. For GLAs, the resident list must be submitted on a periodic basis as determined by the CWD, regardless of if the resident has selected the GLA to act as an authorized representative (AR) or they applied on their own.

The [CF 377.5A](#) is a recommended form. The [CF 377.5A](#) serves as a reporting document for a DAA Treatment Center or GLA to inform the CWD of how many CalFresh recipients are residing in their facility on a monthly, semi-monthly, or other periodic basis as determined by the CWD. While the [CF 377.5A](#) is not a mandatory form, CWDs who create an alternative form are required to collect from the DAA Treatment Centers and GLAs the same data elements that are captured in the attached sample form.

**Drug Addiction or Alcoholic Treatment Centers and Group Living Arrangements: Change Report for Departing Residents (CF 377.5B)**

As stated in [ACL No. 19-51](#), when a household leaves a DAA Treatment Center or GLA, the DAA Treatment Center or GLA must notify the CWD of the household's departure by sending a completed change report form to the CWD with the household's new address, if available, and a statement that the DAA Treatment Center or GLA designated employee no longer represents the household as an AR for their CalFresh case (if applicable). For GLAs that have residents who do not have an AR, this form is still required to be submitted when a CalFresh resident leaves.

The [CF 377.5B](#) is a recommended form. The [CF 377.5B](#) serves as a change reporting document for a DAA Treatment Center or GLA to inform the CWD of a household change of address and provide the household's new address, if available. Additionally, this form acts as a statement that the DAA Treatment Center or GLA and respective designated employee is no longer acting as the household's AR (if applicable). While the [CF 377.5B](#) is not a mandatory form, CWDs who create an alternative form are required to collect from the DAA Centers and GLAs the same data elements that are captured in the attached sample form.

**CalFresh Mid-Certification Period Status Report Form (CF 377.5 SAR)**

In addition to the two recommended forms mentioned above, DAA Treatment Centers and GLAs must provide the *CalFresh Mid-Certification Period Status Report* ([CF 377.5 SAR](#)) to residents who are leaving their facilities. Per [ACL No. 19-51](#), a DAA Treatment Center or GLA facility must provide the household with a change report form as soon as it has knowledge that the household plans to leave the facility. They must also advise the household to return the [CF 377.5 SAR](#) to the CWD within 10 days of any change in the household's circumstances that the household is required to report.

**Implementation**

The new [CF 377.5A](#) and [CF 377.5B](#) are posted on the [CDSS website](#) and available upon release of this ACL.

**Camera Ready Copies**

For a camera-ready copy in English, contact the CDSS Forms Management Unit at [fmudds@dss.ca.gov](mailto:fmudds@dss.ca.gov). You may obtain this form from the [CDSS webpage](#) at: <http://www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-by-Program>.

This ACL and other [CDSS Letters and Notices](#) are available on the internet at: <http://www.cdss.ca.gov/inforesources/Letters-and-Notices>.

If you have any questions or need additional guidance regarding the information in this letter and attachments, please contact the CalFresh Policy and Employment Bureau at [CalFreshPolicy@dss.ca.gov](mailto:CalFreshPolicy@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

JENNIFER HERNANDEZ  
Deputy Director  
Family Engagement and Empowerment Division

Attachments

## DRUG ADDICTION OR ALCOHOLIC TREATMENT AND REHABILITATION CENTERS AND GROUP LIVING ARRANGEMENTS: PERIODIC RESIDENT REPORT

**INSTRUCTIONS:**

**Drug Addiction or Alcoholic Treatment & Rehabilitation Centers (DAA Treatment Centers) and Group Living Arrangements (GLA) must provide their County Welfare Department (CWD) a report listing each individual resident receiving CalFresh and residing in their facility. This report must be completed and signed by an authorized DAA Treatment Center or GLA representative. This report should be submitted no later than the 5th of each month. This report must be sent to \_\_\_\_\_ County: (Provide county contact info here)**

Facility Name	Facility Address	City/ZIP
Facility Authorized Representative	Phone Number	Month/Year

	First Name	Last Name	CalFresh Case Number	CalFresh Status (active, pending, etc.)	Facility Entrance Date	Facility Exit Date	Date Notified County of Exit	Amount of Benefit Refund (\$)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

	First Name	Last Name	CalFresh Case Number	CalFresh Status (active, pending, etc.)	Facility Entrance Date	Facility Exit Date	Date Notified County of Exit	Amount of Benefit Refund (\$)
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								

**I understand that per All County Letter No. 19-51, a portion of the CalFresh benefits must be returned to the client upon exiting the facility and that I will contact the county to assist in determining the amount to be returned. I understand that when a client leaves the facility, within 10 days, I must complete the CF 377.5B Change Report Form and I must return the Electronic Benefit Transfer (EBT) card associated with the client's case to the county. I understand that after a client leaves the facility, I am not entitled to spend their CalFresh benefits or use their EBT card. 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.**

\_\_\_\_\_  
DAA Treatment Center or GLA Representative (Print)

\_\_\_\_\_  
DAA Treatment Center or GLA Representative (Signature)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**DRUG ADDICTION OR ALCOHOLIC TREATMENT CENTERS AND GROUP LIVING ARRANGEMENTS: CHANGE REPORT FOR DEPARTING RESIDENTS****INSTRUCTIONS:**

When a Drug Addiction or Alcoholic Treatment Centers (DAA Treatment Center) and Group Living Arrangements (GLA) employee has been designated to act as a resident's Authorized Representative (AR), the AR must notify the County Welfare Department when the individual resident receiving CalFresh leaves the facility. An AR must complete and sign this change report and submit it to the CWD. The AR must include the resident's new address, if available.

Resident Name (First and Last)	Case #	Move Out Date
Facility Name	Facility Authorized Representative Name (First and Last)	

**ADDRESS CHANGE**

Please provide the former resident's new address, if available. ☐ Check here if a new address is unknown

Physical Address

City	State	ZIP Code
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Mailing Address (if different than above)

City	State	ZIP Code
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**VOLUNTARY INFORMATION**

Let us know if you have any additional information to report, such as a change in household composition or income:


**CANCELLATION OF AUTHORIZED REPRESENTATIVE DESIGNATION**

As of \_\_\_\_\_, I hereby cancel \_\_\_\_\_, the Authorized Representative  
(Date) (Authorized Representative's Name)  
status and all related duties for \_\_\_\_\_, a former resident.  
(Former Resident's Name)

**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.**

Signature of Authorized Representative	Phone Number	Date
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