

October 15, 2021

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 21-111**

The purpose of this All County Letter is to inform County Welfare Departments of the three new CalFresh forms: *CalFresh Request for Authorized Representative (CF 101)*, *CalFresh Request for Authorized Representative Drug or Alcohol Treatment Center Resident (CF 100)*, and *CalFresh Student Exemption Screening Form (CF 6177)*.



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

October 15, 2021

ALL COUNTY LETTER NO. 21-111

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

SUBJECT: CALFRESH IMPLEMENTATION OF NEW CALFRESH FORMS

REFERENCE: [7 CODE OF FEDERAL REGULATIONS \(CFR\) § 273.2](#);  
[7 § CFR 273.2\(n\)\(1\)](#), [7 § CFR 273.2\(n\)\(4\)](#); [7 CFR § 271](#);  
[7 CFR § 271.2](#);  
[MANUAL OF POLICY AND PROCEDURES \(MPP\) 63-402.6](#);  
[63-402.614](#); [63-402.612](#); [63-402.633](#); [16-005\(a\)\(4\)](#), [16-505.2](#),  
[63-406.1](#), [63-406.2](#), [23-400.1](#);  
[ALL COUNTY INFORMATION NOTICE \(ACIN\) I-08-18](#),  
[ACIN I-45-11](#), [ACIN I-45-11E](#), [ACIN I-89-15](#);  
[All County Letter \(ACL\) 19-55](#), [ACL 15-70](#), [ACL 17-05](#);  
[Assembly Bill No. 1930 \(CHAPTER 729, Statutes of 2014\)](#)

The purpose of this All County Letter (ACL) is to release three new state forms for CalFresh.

The new forms include:

- [CalFresh Request for Authorized Representative \(CF 101\)](#)
- [CalFresh Request for Authorized Representative Drug or Alcohol Treatment Center Resident \(CF 100\)](#)
- [CalFresh Student Exemption Screening Form \(CF 6177\)](#)

## BACKGROUND

During the Non-State Forms functional design sessions in the Summer of 2019, representatives from the 58 counties, state departments, and consortium, collaborated to map, revise, and improve forms to be shared by all counties once California eligibility

systems move to CalSAWS. These forms were previously used either in the Leader Replacement System (LRS), Consortium IV (C-IV), or California Work Opportunity and Responsibility to Kids Information Network (CalWIN) eligibility system. The efforts between the 58 counties, consortium, and state departments concluded with 108 form requirements for programs managed by both the California Department of Social Services (CDSS) and Department of Health Care Services (DHCS).

By Summer of 2020, in collaboration with CalSAWS and advocate partners, DHCS and CDSS reviewed the 108 form requirements by program to determine which forms would remain non-state forms, transition into state forms, or become obsolete and to no longer be used by any counties. The conclusion of the review effort resulted in three new CalFresh state forms.

### **IMPLEMENTATION TIMELINE**

The new forms will be made available in CalSAWS. CWDs may use previous versions of the forms until CalSAWS is implemented within the county, at which time previous versions become obsolete.

### **NO SUBSTITUTES PERMITTED**

With the release of this letter, all new forms are deemed “No Substitutes Permitted” to ensure statewide consistency and avoid unnecessary costs for upkeep of multiple versions.

The visual design of the forms is intentional. CWDs must not make any changes to the formatting. However, overprinting modifications may be permitted. Overprinting modifications for purposes other than those specified under [MPP 23-400.211](#) must be pre-approved by the CDSS before use of the forms by CWDs. Refer to [MPP 23-400.22](#) for approval procedures. Requests can be submitted to the CalFresh Policy and Employment Bureau at [CalFreshPolicy@dss.ca.gov](mailto:CalFreshPolicy@dss.ca.gov).

This letter supersedes previous guidance that allowed CWDs the option to submit a separate form developed by the CWD for approval for the purposes outlined below.

### **NEW CALFRESH FORMS**

#### **CF 101      CalFresh Request for Authorized Representative**

This form is used to inform households of the option to appoint an Authorized Representative (AR) for: a household, a resident of an independent living arrangement, or a Board and Care/Room and Board facility and to designate an AR. General information will be collected for the AR. The household will select to allow the AR to assist the household at application, complete ongoing reporting and/or access benefits for a specified timeframe. After all selections, the household will complete the

household information section to complete the request. When the CWD receives this request, they will make the appropriate updates to the household's case file.

#### **Directions for Use**

The purpose and intent of this form has not changed. Refer to the guidance provided in [7 CFR 273.2](#), [7 CFR 273.2\(n\)\(1\)](#), [7 CFR 271.2](#); [MPP 63-402.6](#), [63-402.614](#), [63-402.612](#), [63-402.633](#), [16-005\(a\)\(4\)](#), [16-505.2](#); [ACIN I-08-18](#); [ACL 19-55](#).

#### **CF 100      CalFresh Request for Authorized Representative Drug or Alcohol Treatment Center Resident**

This form is used to appoint an AR for a household/resident of a Drug or Alcohol Treatment Center. The household will complete the AR information and Drug or Alcohol Treatment Center Resident sections. The AR will complete the Drug or Alcohol Treatment Center section. After all sections have been completed and the CWD receives this request, they will make the appropriate updates to the household's case file.

#### **Directions for Use**

The purpose and intent of this form has not changed. Refer to the guidance provided in [7 CFR 273.2](#), [7 CFR 273.2\(n\)\(1\)](#), [7 CFR 273.2\(n\)\(4\)](#), [7 CFR 271](#), [7 CFR 271.2](#); [MPP 63-402.6](#), [63-402.614](#), [63-402.612](#), [63-402.633](#), [16-005\(a\)\(4\)](#), [16-505.2](#); [ACIN I-08-18](#); [ACL 19-55](#).

#### **CF 6177      CalFresh Student Exemption Screening Form**

This form may be used to help determine if an exemption applies to a student in the household. The household will select which items apply. The CWD will review the items that were selected to determine if additional verification is needed and if the student meets an exemption from student eligibility rule.

#### **Directions for Use**

The purpose and intent of this form has not changed. Refer to the guidance provided in [7 CFR 273.5](#), [63-406.1](#), [63-406.2](#); [ACIN I-45-11](#), [ACIN I-45-11E](#), [ACIN I-89-15](#); [ACL 15-70](#), [ACL 17-05](#); [Assembly Bill No. 1930 \(CHAPTER 729, Statutes of 2014\)](#)

#### **COPIES AND TRANSLATIONS**

Forms referenced in this letter are available on the [CDSS Forms-Brochures web page](#).

When all translations are completed per [MPP §21-115.2](#), they are posted on the [Translated Forms and Publications web page](#). For questions on translated materials, please contact Language Services at (916) 651- 8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the [GEN 1365-Notice of Language Services](#) and a local contact number.

Per California Code Section 7290 et seq, the CWDs must ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services must be provided, free of charge, to the applicant/recipient. If CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it.

Additionally, the CWDs must ensure that individuals with disabilities are provided services such as auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision, or manual skills, where necessary. More information regarding provisions for services to applicants and recipients who are non-English speaking or who have disabilities can be found in [MPP Section 21-115](#).

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, 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

**CALFRESH REQUEST FOR AUTHORIZED REPRESENTATIVE**

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COUNTY USE ONLY	
Case Name:	Case Number:
Worker Name:	Worker Number:

An Authorized Representative (AR) is someone you choose to act on your behalf and manage your CalFresh benefits. You can choose a family member, friend, or other trusted person to become your Authorized Representative.

Authorized Representatives must be at least 18 years old and may need to provide proof of their identity to the County if applying for benefits for the household. Choosing an AR is optional, and your benefits will not change if you do not sign this form. The person you choose as your AR will be listed on your CalFresh case as your AR until the end of your certification period, or until the date you choose to end authorization, whichever comes first. You may remove an AR at any time, verbally or in writing, without any change to your benefits.

A responsible household member may designate one or more ARs. If you would like more than one AR, please fill out a separate form for each individual.

**INSTRUCTIONS:**

Complete **Sections A through C** to choose an AR for a household, a resident of an independent living arrangement; or a resident of a Board and Care/Room and Board facility.

SECTION A: AUTHORIZED REPRESENTATIVE INFORMATION			
Name (Last, First, Middle)		Birth Date	Phone Number
Organization			
Address	City	State	Zip Code

**SECTION B: AUTHORIZED REPRESENTATIVE OPTIONS**

Please check all the boxes that apply.

I authorize the person identified above to act as the household's AR to:

- ☐ **Apply** - Sign my application and be interviewed, give all information needed for my application, complete forms, get notices, and speak for me at a hearing if the application decision is appealed.
- ☐ **Complete Ongoing Reporting** – Report changes, attend recertification interview, and receive ongoing notices. Note: Do not check this if the representative will not continue to act on your behalf after the application decision is made.
- ☐ **Access to Benefits** - Allows your AR to access benefits to purchase food for you. Your AR will be issued their own card with access to the full amount of your CalFresh benefits. You may call the county at any time to cancel their access.

Please check one box.

From the date this form is signed, I authorize the person identified above to act as my household's AR until:

- ☐ Application decision is made.
- ☐ End of my current certification period.
- ☐ \_\_\_\_\_ (date).

**SECTION C: HOUSEHOLD INFORMATION**

**As the CalFresh Household, I understand that I have the responsibility to accept any consequences of the authorized representative's actions as I would my own.**

**As the CalFresh Household, I understand that I have the right to:**

- Choose anyone that I want to be my authorized representative;
- End this appointment at any time by telling the county verbally or in writing; and
- Request a fair hearing when I do not agree with an action the county takes.

Name (Last, First, Middle)		Birth Date	Phone Number
Address	City	State	Zip Code
Household Member Signature			

**CALFRESH REQUEST FOR AUTHORIZED REPRESENTATIVE  
DRUG OR ALCOHOL TREATMENT CENTER RESIDENT**

COUNTY USE ONLY	
Case Name:	Case Number:
Worker Name:	Worker Number:

**INSTRUCTIONS:**

To choose an Authorized Representative (AR) for a resident of a Drug or Alcohol Treatment Center the Resident/CalFresh Household must complete **Sections A and C** and AR must complete **Section B**.

SECTION A: AUTHORIZED REPRESENTATIVE INFORMATION			
Name (Last, First, Middle)	Birth Date	Phone Number	
Organization			
Address	City	State	Zip Code

SECTION B: DRUG OR ALCOHOL TREATMENT CENTER			
We _____ (Name of Facility Employees Who will be AR)			
have been given the authority to act as ARs for the residents of:			
_____ (Name of Facility)			
We understand that the facility is responsible to the County for accurately reporting all information related to the below signed resident's situation. We have reviewed the "Special CalFresh Requirements for Drug/Alcohol Treatment Centers" and understand our facility's responsibilities. We also understand that the facility will be held liable for any overissuances resulting from information reported by us.			
Name (Last, First, Middle)	Title	Signature	Date
Name (Last, First, Middle)	Title	Signature	Date



**SECTION C: DRUG OR ALCOHOL TREATMENT CENTER RESIDENT**

I authorize employees of the \_\_\_\_\_ listed above to  
(Name of Facility)

act as my AR in making an application for CalFresh, picking up, and using my CalFresh benefits, report changes, attend recertification interview, and receive ongoing notices because I am a participating resident of a drug/alcohol treatment center.

Name (Last, First, Middle)		Birth Date	Phone Number
Address	City	State	Zip Code
Household Member Signature			

**CALFRESH STUDENT EXEMPTION SCREENING FORM**  
**(TO BE COMPLETED BY THE STUDENT)**

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**Student Name:** \_\_\_\_\_ **School Name:** \_\_\_\_\_

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**Current Enrollment Status:**    ☐ Half-Time or More    ☐ Less Than Half-Time

Students are required to meet additional criteria to be determined eligible for CalFresh. If a student meets the additional criteria, they may qualify for an exemption. To help the county determine if they qualify for an exemption, please complete the information requested below.

**Check all that apply to the student listed above:**

- ☐ Approved for work study (even if a work study job assignment has not yet begun or is not available) and anticipate working during the school term and has not refused a work assignment
- ☐ Taking non-credit courses or are taking Adult Education courses
- ☐ Approved for a TANF-funded Cal Grant A or B and received proof from California Student Aid Commission
- ☐ Working an average of 20 hours per week or a total of 80 hours per month
- ☐ Disabled or physically or mentally unable to work
- ☐ Does not expect to be enrolled next term
- ☐ Responsible for the care of a dependent in the household under the age of 6 or a child under 12 without adequate childcare
- ☐ A single parent responsible for the care of a dependent in the household under the age of 12
- ☐ Receiving CalWORKs

**Check all programs that apply to the student listed above:**

- ☐ Workforce Innovation and Opportunity Act (WIOA)
- ☐ Mathematics, Engineering Science Achievement (MESA) Program
- ☐ Educational Opportunity Program (EOP)
- ☐ Chafee Educational Training Voucher (ETV) Program
- ☐ Extended Opportunity Programs and Services (EOPS)
- ☐ College Disabled Students Program and Services/Student Academic Support (DSPS) or Student Academic Services (SAS)
- ☐ Cooperative Agencies Resources for Education (CARE) Program
- ☐ McNair Scholars Program
- ☐ Foster Youth Success Initiative (FYSI)
- ☐ Cooperating Agencies Foster Youth Educational Support (CAFYES)
- ☐ Unaccompanied Refugee Minors (URM) Program
- ☐ Extended Foster Care (AB 12/AB 212)
- ☐ Guardian Scholars Program
- ☐ CalFresh Employment and Training
- ☐ An approved program to increase student employability

***\*If you marked any of the boxes above you may be asked by your County to provide proof, such as approval or award letter, student aid report or other proof of participation.***