

March 9, 2023

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

ALL COUNTY LETTER NO. 23-26

The purpose of this All County Letter is to inform County Welfare Departments of six new forms: *Examples of Verification (GEN 100)*, *Appointment Letter (CF 102)*, *Message from the County (GEN 107)*, *Employer Statement Form (GEN 111)*, *Sworn Statement (GEN 853)*, and *Request to Stop My Benefits (GEN 788)*. It is also to inform County Welfare Departments of updates to the contact information for the California Department of Social Services (CDSS) Civil Rights Unit (CRU) on the following forms: *Application for CalFresh Benefits (CF 285)*, *Application for CalFresh Benefits Large Print (CF 285LP)*, *Information for Households Applying for CalFresh with the Social Security Administration (CF SSA1)*, and *Information for Households Applying for CalFresh with the Social Security Administration Large Print (CF SSA1LP)*.



KIM JOHNSON
DIRECTOR

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



GAVIN NEWSOM
GOVERNOR

March 9, 2023

ALL COUNTY LETTER NO. 23-26

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

SUBJECT: CALFRESH AND CALIFORNIA WORK OPPORTUNITY AND
RESPONSIBILITY TO KIDS (CalWORKs) IMPLEMENTATION OF
NEW FORMS AND CDSS CIVIL RIGHTS CONTACT
INFORMATION UPDATE

REFERENCE: [7 CODE OF FEDERAL REGULATIONS \(CFR\) 273.14\(b\)\(J\)\(iii\);](#)
[MANUAL OF POLICIES AND PROCEDURES \(MPP\) SECTIONS](#)
[22-072](#), [MPP 23-400.211](#), [MPP 23-400.22](#), [MPP 40-103](#), [MPP 40-](#)
[115.22](#), [MPP 40-129.72](#), [MPP 63-300.5](#), [MPP 63-300.5\(e\)\(1\)](#),
[MPP 63-300\(g\)\(3\)](#), [MPP 63-300\(h\)\(1\)](#), [MPP 63-509\(g\)](#); [ALL](#)
[COUNTY INFORMATION NOTICE \(ACIN\) I-02-14](#), [ACIN I-45-11](#),
[ACIN I-45-11E](#); [ALL COUNTY LETTER \(ACL\) 14-20](#), [ACL 21-02](#),
[ACL 21-134](#) and [ACL 21-140](#)

The purpose of this All County Letter (ACL) is to release new state forms and instructions for use of the forms. The new forms include:

- Examples of Verification (GEN 100)
- Appointment Letter (GEN 102)
- Message from the County (GEN 107)
- Employer Statement Form (GEN 111)
- Sworn Statement (GEN 853)
- Request to Stop My Benefits (GEN 788)

This ACL is also informing CWDs of updates to the contact information to the CDSS Civil Rights Unit for the following forms:

- Application for CalFresh Benefits (CF 285)
- Application for CalFresh Benefits Large Print (CF 285LP)
- Information for Households Applying for CalFresh with the Social Security Administration (CF SSA1)
- Information for Households Applying for CalFresh with the Social Security Administration Large Print (CF SSA1LP).

Background for New State Forms

During the 2019 Non-State Forms functional design sessions, representatives from the 58 counties, state departments, and consortium collaborated to map, revise, and improve forms to be shared by all counties once migration to the California Statewide Automated Welfare System (CalSAWS) was complete. 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 systems. 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).

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. The conclusion of the review effort resulted in six new CalFresh and CalWORKs state forms.

Implementation Timeline

The new forms will be made available in CalSAWS for use across all 58 counties. CWDs may continue to use previous versions of the forms until CalSAWS is implemented within their county, at which time previous versions will become obsolete.

No Substitutes Permitted

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

The visual design of the forms is intentional. As described in [ACL 21-02](#), 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 and Shawn Dorris, CalWORKs Program Manager at Shawn.Dorris@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 and CalWORKs Forms

Form No.	Form Title, Description, and Directions for Use
GEN 100	<p><u>Examples of Verification</u></p> <p>The purpose of this document is to assist the CalFresh household and/or CalWORKs Assistance Unit (AU) by providing examples of verifications that may be necessary for eligibility determinations in each program.</p> <p>Directions for Use</p> <p>The CWD may provide this list of <u>examples</u> to households and/or AUs of possible verifications. Verifications shall not be limited to any single type of document if multiple sources are available unless specified in statute or regulation.</p> <p>Related Information</p> <p>For more information on verification requirements in the CalFresh program see ACIN I-45-11 and ACIN I-45-11E. For CalWORKs see MPP 40-129.72.</p>
GEN 102	<p><u>Appointment Letter</u></p> <p>This letter is used to notify CalFresh households and/or CalWORKs applicants/recipients of their scheduled interview for one or more programs. This letter is recommended to be used at initial application and required to be used at recertification/redetermination when scheduling interviews.</p> <p>Directions for Use</p> <p>The CWD will select the appropriate program(s) for the interview and will specify all appointment details.</p> <p>CWDs may continue to use the CF 29 series or approved CWD created appointment letter until the GEN 102 is automated.</p>

	<p>Related Information</p> <p>For more information on notification of interviews in CalFresh see ACL 14-20; 7 CFR 273.14(b)(1)(iii). For CalWORKs see MPP 40-131.</p>
GEN 107	<p><u>Message from the County</u></p> <p>The purpose of this form is to provide the household with information necessary for their case when other approved forms, letters, and notices are not sufficient.</p> <p>Directions for Use</p> <p>The CWD may use this letter to communicate information to the household or AU that cannot be communicated with other approved forms, letters, and notices. Information communicated to the household or assistance unit with this letter must still be in compliance with program requirements.</p> <p>For CalWORKs, some CalWORKs MPPs require use of a form approved by the state to notify the applicant or recipient, but a formal form, letter or NOA has not been developed. This letter template can be used to communicate with the AU or CalWORKs individual as the officially approved form when a form, notice of action or informing notice does not exist for the purpose intended. All rules within the MPP must be followed when using this template as the approved state form. When used for purposes equivalent to a NOA, adequate and timely notice rules apply as described in ACIN I-01-14. Additionally, if used to take a negative action impacting the family receiving CalWORKs, the most current NA Back 9 must be used in conjunction with the notice.</p>
GEN 111	<p><u>Employer Statement Form</u></p> <p>This form is used to assist households and/or AUs in verifying employment and income information when other verification may not be available. It is not intended as the only form of verification and must not replace the CWD's acceptance of other documentation.</p> <p>Directions for Use</p> <p>General information for the employee and employer will be collected in Section 1, and the authorization becomes valid</p>

	<p>when signed and dated by the employee. Only one employee and employer should be listed on a single form. The CWD will mark only one of the Employer Sections boxes to indicate which sections should be completed by the employer, according to program requirements. The form may be provided to the employer either by the household/AU or by the CWD on behalf of the household.</p> <p>For CalWORKs, this form shall be used only if all other methods have been attempted or unless the applicant/recipient requests assistance from the CWD to obtain verification from the employer.</p> <p>Related Information</p> <p>Refer to guidance provided in MPP 44-103, MPP 63-300.5, 63-300.5(e)(1), 63-300.5(g)(3), 63-300.5(h)(1); ACIN I-45-11, and ACIN I-45-11E.</p>
GEN 853	<p><u>Sworn Statement</u></p> <p>This form may be used to assist in verifying required information by allowing CalFresh households and/or CalWORKs applicants/recipients to declare a written statement under penalty of perjury, when other verifications are not available.</p> <p>Directions for Use</p> <p>The CWD may provide this form to individuals to self-attest required program information. All programs must continue to follow verification regulations.</p> <p>For CalWORKs, self-attestation/sworn statements cannot be accepted for proof of citizenship or pregnancy verification, except as defined in ACL 21-134 and 21-140; and if the individual does not have a Social Security Number (SSN) but has applied. In the case of an SSN application, proof from the Social Security Administration is required as verification for the individual that has applied.</p> <p>Related Information</p> <p>Refer to the verification guidelines provided in MPP 40-115.22; 63-300.5; ACL 21-134, ACL 21-140, ACIN I-45-11; ACIN I-45-11E.</p>

GEN 788	<p><u>Request to Stop My Benefits</u></p> <p>This form may be used by a CalFresh household and/or CalWORKs assistance unit to request a voluntary discontinuance of programs and/or services. Additionally, the form allows for a waiver of the 10-day notice requirement to stop services for specified programs.</p> <p>Directions for Use</p> <p>The CWD may provide this form to households or AUs to request a voluntary discontinuance of programs and/or services. For specified programs a waiver for 10-day noticing can be requested. All programs must continue to follow discontinuance and noticing regulations specific to their program. The household or AU does not need to choose both discontinuance of a program and/or service and the 10-day waiver for the form to be complete.</p> <p>Related Information</p> <p>For more information on discontinuance and 10-day notice refer to MPP 63-509(g) and MPP 22-072.</p>
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Background for Revised State Forms

In 2021, the California Department of Social Services (CDSS) Civil Rights Unit (CRU) updated its mail station and fax number, resulting in changes to some CalFresh forms. The following forms were updated to include the new mail station and fax number: CF 285, CF 285 LP, CF SSA1 and CF SSA1LP.

See below for revised language on each form. The formatting of the updated forms may differ from previous versions to comply with the Americans with Disabilities Act.

Implementation Timeline

The revised forms are available on the CDSS website. CWDs may exhaust current stock of forms. Once current stock is exhausted, CWDs must begin using the revised forms. Revised forms will be automated as soon as administratively possible.

Revised State Forms

Form No.	Form Title, Original Language, and Revised Language
CF 285	<p data-bbox="516 514 1019 552"><u>Application for CalFresh Benefits</u></p> <p data-bbox="508 619 1409 688">The original language under “Nondiscrimination Statement” on the CF 285 reads:</p> <p data-bbox="508 709 1170 903">(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, S.W. Washington D.C. 20250-9410</p> <p data-bbox="508 972 959 1220">CDSS Civil Rights Bureau P.O. BOX 944243, M.S. 8-16-70 Sacramento, CA 94244-2430 1-866-741-6241 (Toll Free)</p> <p data-bbox="508 1287 927 1325">(2) fax: USDA (202) 690-7442</p> <p data-bbox="508 1394 935 1432">The revised language reads:</p> <p data-bbox="508 1451 1170 1644">(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, S.W. Washington D.C. 20250-9410</p> <p data-bbox="508 1711 1141 1904">CDSS Civil Rights Bureau P.O. BOX 944243, M.S. 8-16-70 M.S. 9-7-041 Sacramento, CA 94244-2430</p>

	<p>1-866-741-6241 (Toll Free)</p> <p>(2) fax: USDA (202) 690-7442, CDSS (916) 651-0602</p>
CF 285LP	<p><u>Application for CalFresh Benefits Large Print</u></p> <p><u>The original language under “Nondiscrimination Statement” on the CF 285LP reads:</u></p> <p><u>(1) mail: U.S. Department of Agriculture</u> <u>Office of the Assistant Secretary for Civil Rights</u> <u>1400 Independence Avenue, S.W.</u> <u>Washington D.C. 20250-9410</u></p> <p><u>CDSS</u> <u>Civil Rights Bureau</u> <u>P.O. BOX 944243, M.S. 8-16-70</u> <u>Sacramento, CA 94244-2430</u> <u>1-866-741-6241 (Toll Free)</u></p> <p><u>(2) fax: USDA (202) 690-7442</u></p> <p><u>The revised language reads:</u></p> <p><u>(1) mail: U.S. Department of Agriculture</u> <u>Office of the Assistant Secretary for Civil Rights</u> <u>1400 Independence Avenue, S.W.</u> <u>Washington D.C. 20250-9410</u></p> <p><u>CDSS</u> <u>Civil Rights Bureau</u></p>

	<p><u>P.O.BOX 944243, M.S. 8-16-70-M.S. 9-7-041</u> <u>Sacramento, CA 94244-2430</u> <u>1-866-741-6241 (Toll Free)</u></p> <p><u>(2) fax: USDA (202) 690-7442, CDSS (916) 651-0602</u></p>
CF SSA1	<p><u>Information for Households Applying for CalFresh with the Social Security Administration</u></p> <p><u>The original language under “Discrimination Prohibition and Complaint Process” on the CF SSA1 reads:</u></p> <p><u>(1) Mail: U.S. Department of Agriculture</u> <u>Office of the Assistant Secretary for Civil Rights</u> <u>1400 Independence Avenue, S.W.</u> <u>Washington D.C. 20250-9410</u></p> <p><u>CDSS, Civil Rights Bureau</u> <u>P.O. BOX 944243, M.S. 8-16-70</u> <u>Sacramento, CA 94244-2430</u> <u>(866) 741-6241 (toll free)</u></p> <p><u>(2) Fax: (202) 690-7442</u></p> <p><u>The revised language reads:</u></p> <p><u>(1) Mail: U.S. Department of Agriculture</u> <u>Office of the Assistant Secretary for Civil Rights</u> <u>1400 Independence Avenue, S.W.</u></p>

	<p><u>Washington D.C. 20250-9410</u></p> <p><u>CDSS, Civil Rights Bureau</u> <u>P.O. BOX 944243, M.S. 8-16-70 M.S. 9-7-041</u> <u>Sacramento, CA 94244-2430</u> <u>(866) 741-6241 (toll free)</u></p> <p><u>(2) Fax: (202) 690-7442, CDSS (916) 651-0602</u></p>
CF SSA1LP	<p><u>Information for Households Applying for CalFresh with the Social Security Administration Large Print</u></p> <p><u>The original language under “Discrimination Prohibition and Complaint Process” on the CF SSA1LP reads:</u></p> <p><u>(1) Mail: U.S. Department of Agriculture</u> <u>Office of the Assistant Secretary for Civil Rights</u> <u>1400 Independence Avenue, S.W.</u> <u>Washington D.C. 20250-9410</u></p> <p><u>CDSS, Civil Rights Bureau</u> <u>P.O. BOX 944243, M.S. 8-16-70</u> <u>Sacramento, CA 94244-2430</u> <u>(866) 741-6241 (toll free)</u></p> <p><u>(2) Fax: (202) 690-7442</u></p> <p><u>The revised language reads:</u></p>

	<p><u>(1) Mail: U.S. Department of Agriculture</u> <u>Office of the Assistant Secretary for Civil Rights</u> <u>1400 Independence Avenue, S.W.</u> <u>Washington D.C. 20250-9410</u></p> <p><u>CDSS, Civil Rights Bureau</u> <u>P.O. BOX 944243, M.S. 8-16-70 M.S. 9-7-041</u> <u>Sacramento, CA 94244-2430</u> <u>(866) 741-6241 (toll free)</u></p> <p><u>(2) Fax: (202) 690-7442, CDSS (916) 651-0602</u></p>
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Copies and Translations

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

When CDSS completes all translations of a form, they are posted are completed per they are posted on the [Translated Forms and Publications](#) webpage. When made available by CDSS, forms translated into an individual's preferred language must be provided to the individual pursuant to [Manual of Policies and Procedures \(MPP\) Section 21-115.2](#). For questions on translated materials, please contact Language Services at (916) 651- 8876. If translations are not 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](#) and [ACL 19-45](#).

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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.

For questions related to the CalWORKs Program email the CalWORKs Early Engagement and Eligibility Bureau at CWEligibilityPolicy@dss.ca.gov or at CFRB@dss.ca.gov.

Sincerely,

Original Document Signed By

JENNIFER TROIA
Chief Deputy Director

Attachments

EXAMPLES OF VERIFICATION

To determine your eligibility for benefits, you may be asked to give us proof of income, expenses, property, and resources for you and your household members.

Listed below are examples of the proof and documents you may be asked to give us - you may not need to give us every document listed. Some documents may not apply to your household or family members.

If you have other types of proof not listed or have any questions, please contact the county.

Birth/Citizenship

- Birth certificate
(original documents are required for Medi-Cal)
- U.S. Passport
- Certificate of naturalization
- Baptismal certificate
(with date and place of birth)
- Statement of witness to birth

Income

- 30 days of paycheck stub(s)
- Letter from employer with gross pay, hours worked, etc.
- Copy of child support check or payment stub
- Benefits award letter (Social Security/Veterans/Unemployment/Disability, etc.)
- Self-employment tax forms
(IRS Schedule C, etc.)
- Receipts for work expenses if you are self-employed
- School grants/loans/financial aid statements
- Sponsor statement form

Immigration Status

- Immigration papers/forms/cards
(copy both sides)
- Other proof from immigration (USCIS), such as: work authorization, letter of decision or court order, etc.

Identity

- Driver's license or Identification card
- Photo ID
(from government agency, school, etc.)
- Passport
- USCIS (INS) documents

Property/Resources

- Vehicle registration
- Proof of loans or debts/liens on property
- Statement of joint ownership
- Mortgage bill(s)
- Property deed
- Bank statements
- Life insurance policy, stocks, bonds, IRAs
- Most recent retirement account statement(s)
- Sponsor statement form
- Settlements such as lawsuits and insurance claims
- Burial plots/crypts

Other Proof

- Child/dependent or Elderly Adult day care receipts
- Statement from child/dependent care provider
- Receipts for school expenses
- Canceled check/receipt for child/spousal support payments
- Death certificate, obituary, witness statement of death
- Court papers (child/spousal support order)
- School attendance records

Relationship

- Marriage certificate
- Domestic partner certificate
- Birth certificate
- Court papers
(divorce, guardianship, adoption, etc.)
- Paternity Declaration (POP) papers

Housing and Utility Costs

- Rental agreement or rent receipts
- Mortgage bill
- Utility bill
- Property tax statement
- Home or renter's insurance bills
- Hotel/motel receipt
- Canceled checks or copies
- Statement explaining housing arrangement

Residence

- Postmarked envelope or postcard addressed to you
- Utility bill
- Rental agreement
- Bill or other document(s) with your name and address
- Driver's license or Identification card
- Eviction notice/notice to pay rent or quit

Medical Expenses

- Medical bills or receipts
- Medical transportation bills or receipts
- Health or dental insurance policies or premiums
- Medicare card (for Medi-Cal only)
- Cost associated with maintaining a Service Animal

Medical Verification

- Proof of pregnancy from doctor or clinic, with expected due date
- Doctor statement or disability finding by an agency (SSA/SDI/VA, etc.)
- Medical verification form (CW 61)

Immunization Records (for children under 6)

- Stamped shot record/Immunization card
- Statement that immunizations are against your beliefs
- Statement from parent or caretaker relative explaining why you can't get immunizations
- Statement from doctor that immunizations are not available

APPOINTMENT LETTER

COUNTY OF _____

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

(Addressee)

☐ CalFresh☐ CalWORKs☐ Other: _____

- ☐ **You have a phone interview with a scheduled appointment time. We will call you at the phone number listed below. If we cannot reach you at the phone number listed below, we will try to reach you at an alternative phone number if you have provided one.**

Appointment Date:	Appointment Time:
Your Phone Number:	Alternative Phone Number:

- ☐ **You have a phone interview with a flexible appointment time.**

☐ You must call the county during the appointment times listed below on your appointment date.

☐ The county will call you during the appointment times listed below on your appointment date.

Appointment Date:	Appointment Time Between: and
Your Phone Number:	County Phone Number:

- ☐ **You have an in-person interview appointment. Please go to the county office at the date and time listed below.**

Appointment Date:	Appointment Time:		
County Office Name:			
County Office Address:	City:	State:	Zip Code:

IMPORTANT REMINDERS

- Please make sure that the contact number you provided to the county is correct. If it is not correct, call the county at the number listed above right away to update your information.
- The county's phone number may show up as private or unknown when they call. It is important that your phone can accept private or unknown numbers.
- If you have been scheduled for a phone interview, you have the right to be interviewed in-person if you choose. Please call the county at the number listed above if you would like to schedule an in-person interview.
- If you need to reschedule your interview for any reason, call the county right away to reschedule.
- For CalWORKs, if both parents are in the home, you must both attend the in-person or phone interview.
- Failure to complete the interview may cause a delay in processing your application and receiving your benefits. If you already get benefits, it may cause your benefits to stop. If you miss your interview you will have to reschedule it.
- To determine your eligibility for benefits, you may be asked to provide proof of your circumstances. If you are required to provide proof, you must turn it in within 10 days of the county asking for it. Please tell the county if you need help getting this information. The county can help you get it.
- If you need accommodations for your appointment, let the county know right away.

COMMENTS:

MESSAGE FROM THE COUNTY

COUNTY OF

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

(Addressee)

EMPLOYER STATEMENT FORM

Employee Section:

- Section 1 must be completed by the Employee.

SECTION 1. EMPLOYEE AUTHORIZATION		
Name of Employee/Client (Last, First, Middle):	Phone Number:	Date of Birth:
<p>I authorize _____ (Name of Employer)</p> <p>to release information to the county office from my employment records.</p> <p>I understand this authorization may be used by the county office for up to one year to get employment information. I may end this authorization at any time, but the county can keep any information it already has. This information is needed by the county office to see if I am eligible for benefits. This information will be kept in my case file and will not be given to or shared with anyone unless it is required or allowed by law. I have read this form (or had this form read to me) after it was completed. I know I can get a copy of this form if I ask for it.</p>		
Employee/Client Signature:		Date Signed:

Employer Sections:

Sections 2 and 4 must be completed by Employer.

Sections 2 through 4 must be completed by Employer.

SECTION 2. EMPLOYMENT INFORMATION			
Employer/Company Name:	Phone Number:		
Employer Address:	City:	State:	Zip Code:
<p>1. Date employee started working: _____ (Month/Day/Year)</p>			

2. RECORD OF GROSS EARNINGS FOR THE PERIOD OF: _____

You may include photocopies of payroll records, or computer/payroll printouts of each pay period.

Period Ending From - To	Date Paid	Hours Worked	Gross Pay	Period Ending From - To	Date Paid	Hours Worked	Gross Pay

3. Is the employee still employed?

Yes

No

a. If no, check the reason(s):

Employee quit

Employee laid off

Employee fired

Leave of Absence

Other: _____

b. Last Day Worked: _____

(Month/Day/Year)

c. Date Last Pay Received: _____

(Month/Day/Year)

SECTION 3. ADDITIONAL INFORMATION

4. Any vacation, leave, sick or retirement, etc. pay expected? Yes No

If yes, how much, and when will they receive it: _____

5. Is employee receiving health insurance benefits: Yes No

If yes, who is covered on the policy?: _____

If yes, when is the effective date of health insurance?: _____

If the employee pays a premium, how much is it?: _____

Are the following benefits covered?: **Dental:** Yes No **Vision:** Yes No

6 Is full or part-time work available now or in the near future? Yes No

If yes, indicate how many hours are available and when the employee can start working those hours:

SECTION 4. CERTIFICATION OF EMPLOYER

Name:

Title:

Phone Number:

Fax Number:

Signature:

Date Signed:

SWORN STATEMENT

COUNTY OF _____

Notice Date : _____
Case Name : _____
Worker Name : _____
Worker Number : _____
Work Phone/Fax : _____

Name (Last, First, Middle):			
Street Address:	City:	State:	Zip Code:
Home Telephone Number:	Contact/Cell Phone Number:		

I declare as follows:

REQUIRED

I declare under penalty of perjury that the statements made herein are true and correct to the best of my knowledge and belief. I am aware that it is unlawful to give false information.

Signature or Mark:	Date Signed:
Signature or Mark:	Date Signed:

REQUEST TO STOP MY BENEFITS

COUNTY OF _____

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

(Addressee)

Stopping My Benefits

I want to stop my benefits for the program(s) selected below starting on _____

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> CalWORKs | <input type="checkbox"/> CalFresh | <input type="checkbox"/> Child Care | <input type="checkbox"/> CAPI |
| <input type="checkbox"/> Refugee Cash Assistance | <input type="checkbox"/> Ancillary Services | <input type="checkbox"/> Support Services | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Other: _____ | | | |

I understand that I may reapply at any time.

Giving Up 10-Day Notice

I give up my right to a ten-day notice for the program(s) selected below:

- | | | |
|---------------------------------------|-------------------------------|--|
| <input type="checkbox"/> CalWORKs | <input type="checkbox"/> CAPI | <input type="checkbox"/> Refugee Cash Assistance |
| <input type="checkbox"/> Other: _____ | | |

I understand that I am supposed to get a ten-day notice before this action happens. However, since I am asking that my benefits stop, I do not need a ten-day notice that my benefits will stop. The county will send me a letter that confirms they got my request and are stopping my benefits.

I understand that I may reapply at any time.

Signature

Date



APPLICATION FOR CALFRESH BENEFITS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?

Use this application if you are applying for CalFresh benefits only. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you wish to apply for programs other than CalFresh such as, CalWORKs or Medi-Cal, please ask for an application to apply for other programs. You can also apply for CalFresh or other programs online by going to <http://www.benefitscal.org/>.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1) to begin the application process.
- Give the application to the County in person, by mail, by fax, or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?

- Read about your rights and your responsibilities (Program Rules pages 1 through 5) before you sign the application.
- You must have an interview with the County to discuss your application. Most interviews are done by phone, but it can be done in person at the County office or other place arranged with the County. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?

It may take up to 30 days to process your application. You may be able to get benefits within 3 calendar days, if you meet one of the Expedited Service criteria:

- Your household's monthly gross income (income before deductions) is less than \$150 and your cash on hand or in checking or savings accounts is \$100 or less; or
- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and cash on hand or in checking or savings accounts; or
- You are a migrant or seasonal farmworker household with less than \$100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than \$25 in the next 10 days.

To help the County see if you can get benefits in three days, please answer questions 1, 6 through 8, 11, and 16, and give the County proof of your identity (if you have it) with the application.

The County will send you a letter to let you know if your household is approved or denied CalFresh benefits.

Agency Conference

Agency conference is a process that provides the household the right to request a meeting with an eligibility supervisor (this meeting may be attended by an eligibility worker and an authorized representative) to informally resolve any dispute as to whether the household meets Expedited Service criteria.

The agency conference shall be scheduled within two working days of the request, unless the household requests that it be scheduled later or states that they do not wish to have an agency conference.

What do I need for my interview?

To avoid delays, bring proof of the following with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get CalFresh benefits and the amount of benefits you can get.

Proof Needed to Get Benefits

- Identification (Driver's License, State ID card, passport).
- Where you live (a rental agreement, current bill with your address listed).
- Social Security Numbers (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expense or tax records.
- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for noncitizens applying for benefits (an Alien Registration Card, visa).

NOTE: Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security Number.

Proof Needed to Get More CalFresh Benefits

- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

How do I get/use my CalFresh benefits?

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to use your card.
- If your EBT card is lost, stolen, or destroyed, or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County right away. Make sure all responsible adults and your authorized representative also know how to report one of these problems right away. If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will not be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. For a list of locations near you that accept EBT please go to: <https://www.ebt.ca.gov>.
- CalFresh benefits are only for you and your household members. Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.

What if I am homeless?

Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh, homeless means you are:

- A. Staying in a supervised shelter, halfway house, or similar place.
- B. Staying at the home of another person or family for no more than 90 days straight.
- C. Sleeping in a place not designed for, or normally used as, a place to sleep (e.g., a hallway, a bus station, a lobby, or similar places).

Informational Page - Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. If you don't meet your household's reporting requirements your case will be closed or your CalFresh benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with County, State, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any CalFresh benefits that you were not eligible to get.

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application for CalFresh and get an explanation of the rules.
- Ask for help to get proof that is needed.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days.
- Get at least 10 days to give the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your CalFresh case. If you ask for a hearing before an action on your CalFresh case takes place, your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any over paid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone number – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349**. You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.
- Get assistance from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

Please take and keep for your records

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh benefits that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive.

<p>Program Violations For CalFresh: I understand I may have committed an intentional program violation if I do any of the following:</p> <ul style="list-style-type: none"> • Hide information or make false statements • Use Electronic Benefit Transfer (EBT) cards that belong to someone else or let someone else use my card • Use CalFresh benefits to buy alcohol or tobacco • Trade, buy, sell, steal or give away CalFresh benefits or EBT cards, or <u>attempt</u> to trade, buy, sell, steal or give away CalFresh benefits or EBT cards • Try to get dual benefits, for example, apply in two or more different counties or states at the same time • Submit false documents for children or adult household members who are not eligible or who do not exist • Violate conditions of my probation or parole • Flee after a felony conviction • Purchase (buy) a product with CalFresh benefits that has a return deposit, intentionally (on purpose) throw away the contents and return the container for the deposit amount or <u>attempt</u> to return the container for the deposit amount • Buy a product with CalFresh benefits and intentionally resell it for cash or anything other than eligible food 	<p>Penalties I may:</p> <ul style="list-style-type: none"> • Lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me • Lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me • Lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me • Be fined up to \$250,000.00, imprisoned up to 20 years or both
<ul style="list-style-type: none"> • Trade CalFresh benefits or <u>attempt</u> to trade CalFresh benefits for: cash, firearms, non-eligible goods or controlled substances such as drugs 	<ul style="list-style-type: none"> • Lose CalFresh benefits for 24 months for the first offense • Lose CalFresh benefits permanently for the second offense
<ul style="list-style-type: none"> • Give false information about who I am and where I live so I can get extra CalFresh benefits 	<ul style="list-style-type: none"> • Lose CalFresh benefits for 10 years for each offense
<ul style="list-style-type: none"> • Have been convicted of trading, selling or <u>attempting</u> to trade CalFresh benefits worth more than \$500, or trading or <u>attempting</u> to trade CalFresh benefits for firearms, ammunition or explosives 	<ul style="list-style-type: none"> • Lose CalFresh benefits permanently

Please take and keep for your records

Important Information for Noncitizens

- You can apply for and get CalFresh benefits for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.
- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for CalFresh benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for CalFresh benefits.

Privacy Act and Disclosure: You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the requested information, the County may deny your application. You have the right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law allows them to do so. 273.2(b)(4) *Privacy Act statement*. As a County agency, we must notify all households applying and being recertified for CalFresh benefits of the following:

- (i) The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the CalFresh Program. We will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will also be used to monitor compliance with program regulations and for program management.
- (ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- (iii) If a CalFresh claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.
- (iv) Providing the requested information including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of CalFresh benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will check your answers using information in state and federal electronic databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a **consumer reporting agency**. If the information does not match, the County may ask you to send proof.

Please take and keep for your records

Use of Social Security Numbers (SSN)

Everyone applying for CalFresh benefits needs to provide a SSN, if they have one, or proof that they have applied for a SSN (such as a letter from the Social Security Office). The County may deny CalFresh benefits for you or any member of your household who does not give us a SSN. Some people do not have to give SSN's to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the County made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting

Every household that gets CalFresh benefits must report certain changes. Your County will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your CalFresh benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearing

You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request a State hearing. If you ask for a hearing before the action happens, you may be able to keep your CalFresh benefits the same until a decision is made.

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD 3027) found online at <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or contact your County's Civil Rights Coordinator, or write a letter addressed to USDA and provide in the letter all of the information requested in the form or write to California Department of Social Services (CDSS) address below. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410

CDSS
Civil Rights Bureau
P.O.BOX 944243, M.S. 9-7-041
Sacramento, CA 94244-2430
1-866-741-6241 (Toll Free)

(2) fax: USDA (202) 690-7442, CDSS (916) 651-0602; or

(3) email: program.intake@usda.gov

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Case File Reviews

Your case may be selected for additional review to ensure that your eligibility was correctly figured. You must cooperate fully with the County, State, or federal personnel in any investigation or review, including a quality control review. Failure to cooperate in these reviews could result in loss of your benefits.

Work Rules for CalFresh

The County may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped. You may not be eligible for CalFresh if you have recently quit a job without a good reason.

EBT Usage

Any benefit taken from your account before you, another household member, or your authorized representative report the EBT card or PIN has been lost or stolen will **not** be replaced.

Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **not** be replaced.

If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will **not** be replaced.

Please take and keep for your records

NOTES

Please use black or blue ink because it is easy to read and copies best. Please print your answers.

If you need more space to answer a question(s), use page 10 "Additional Writing Space" section and attach additional sheets of paper if needed to provide the information. Please be sure to identify which question you are writing about in the extra space or on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND <u>ARE</u> APPLYING FOR BENEFITS)	
HOME ADDRESS OR DIRECTIONS TO YOUR HOME	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

CONTACT AUTHORIZATION

Please give the county the best contact information to reach you. This will help in processing your application. By providing your contact information below, you are authorizing the county to contact you by phone, email or text, or to leave a phone message regarding your application.

HOME PHONE	CELL PHONE	CHECK BOX FOR TEXT <input type="checkbox"/>
WORK/ALTERNATIVE/MESSAGE PHONE	EMAIL ADDRESS	

Are you homeless? ☐ Yes ☐ No If **yes**, please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)? _____

What language do you prefer to speak (if not English)? _____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

Do you or anyone in your household have a disability (optional question)?

(PLEASE CHECK ONE)
☐ Yes ☐ No

Do you or anyone in your household need an accommodation due to a disability (optional question)?

☐ Yes ☐ No

Has there been a history of domestic violence/abuse (optional question)?

☐ Yes ☐ No

Are you interested in applying for Medi-Cal? If you answer **yes** the County will use your answers to find out if you can get Medi-Cal.

☐ Yes ☐ No

Is your household's monthly gross income less than \$150 and cash on hand, or in checking and savings accounts is \$100 or less?

☐ Yes ☐ No

Is your household's combined monthly gross income and cash on hand or in checking and savings accounts less than the combined cost of rent/mortgage and utilities?

☐ Yes ☐ No

Is your household a migrant/seasonal farm worker household with liquid resources not exceeding \$100 and either your income stopped or you will not get more than \$25 in the next 10 days?

☐ Yes ☐ No

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1) for the CalFresh Program.
- I read, or had read to me, the CalFresh Program Rules and Penalties (Program Rules Page 2).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility for CalFresh is fraud. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits.
- I understand that Social Security Numbers or immigration status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.

SIGNATURE OF APPLICANT (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN)	DATE
---	------

***If you have an Authorized Representative please complete question 2 on the next page.**

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE PHONE NUMBER
--------------------------------	--

Do you want to name someone to receive and spend CalFresh benefits for your household? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

NAME		PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

3. RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	Are you Hispanic or Latino? (Please Check One)	If you are of Hispanic or Latino origin, do you consider yourself:		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mexican	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Cuban
		<input type="checkbox"/> Other _____		

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify) _____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following):

☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You or another adult member in your household will need to have an interview with the County to discuss your application and to receive CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. In-person interviews will only happen during the County's normal office hours.

☐ Please check this box if you would prefer an in-person interview.

☐ Please check this box if you need other arrangements due to a disability.

Please check the boxes below for your preferred day and time for an interview:

Day: ☐ Today ☐ Next available day ☐ Any day ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: ☐ Early morning ☐ Mid-morning ☐ Afternoon ☐ Late afternoon ☐ Anytime

5. OTHER PROGRAMS

Have you or anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Medicaid, Supplemental Nutrition Assistance Program [CalFresh], General Assistance (GA)/General Relief (GR), etc.)? (Please Check One) ☐ Yes ☐ No

IF YES, WHO?	WHERE (COUNTY/STATE)?
IF YES, WHO?	WHERE (COUNTY/STATE)?

6a. HOUSEHOLD'S INFORMATION

Complete the following information for all persons in the home that you buy and prepare food with, including you. **If applying for noncitizens, please complete question 6b and 6c. If not, go to question 6d.**

Social Security number is optional for members not applying for benefits. You must answer the questions below for each person applying for benefits.

Applying for benefits (✓ Check Yes or No)	Name (Last, First, Middle Initial)	How is the person related to you?	Date of birth	Gender (M or F)	U.S. Citizen or National (✓ Check Yes or No) If no, complete question 6b below	Social Security Number
<input type="checkbox"/> Yes <input type="checkbox"/> No		SELF			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list the names of anyone who lives with you that does not buy and prepare food with you:

NAME	NAME
NAME	NAME

6b. NONCITIZEN INFORMATION - Complete for those listed in question 6a above who are not citizens and are applying for aid.

Name	Date of Entry into U.S. (If known)	Give one of the following (if known): Passport Number, Alien Registration Number, etc.	Sponsored? (✓ Check Yes or No) If yes, complete question 6c below:
		DOCUMENT TYPE: _____ DOCUMENT NUMBER: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DOCUMENT TYPE: _____ DOCUMENT NUMBER: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DOCUMENT TYPE: _____ DOCUMENT NUMBER: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does anyone listed above have at least 10 years (40 quarters) of work history or military service in the USA?

(PLEASE CHECK ONE)

If yes, who? _____

☐ Yes ☐ No

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa, U-Visa or VAWA status?

If yes, who? _____

☐ Yes ☐ No

6c. SPONSORED NONCITIZEN INFORMATION - Complete for those listed in question 6b above who are sponsored noncitizens and are applying for aid.

Did the sponsor sign an I-864? ☐ Yes ☐ No If yes, please answer the rest of the question. If the sponsor signed an I-134 then skip this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If yes, how much? \$ _____

Does the sponsor regularly help with any of the following (check all that apply)?

☐ rent ☐ clothes ☐ food ☐ other _____

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

6d. STUDENTS

Is anyone who is applying for benefits including you attending a college or vocational school? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

Name of person	Name of school/training	Enrolled status (✓ Check one)	Are they working?
		<input type="checkbox"/> Half-time or more <input type="checkbox"/> Less than half-time Number of units: _____	Average work hours per week: _____
		<input type="checkbox"/> Half-time or more <input type="checkbox"/> Less than half-time Number of units: _____	Average work hours per week: _____

6e. Is there a foster child living in your home? ☐ Yes ☐ No If **yes**, who? _____

Please answer the following questions about the child(ren):

Was this child(ren) placed in your home under a dependence order of the court? (Please Check One) ☐ Yes ☐ No

Do you want the foster care child(ren) counted in your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, the foster care income you receive will be counted as unearned income.

If **no**, the foster care income will not be counted as unearned income.

7. UNEARNED INCOME

Do you or anyone you buy and prepare food with get income that does not come from a job (unearned)?

(Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- | | | |
|---|--|---|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Veteran benefits, or Military pension | <input type="checkbox"/> Lottery/gambling winnings |
| <input type="checkbox"/> SSI/SSP | <input type="checkbox"/> Financial aid (school grants/loans/scholarships) | <input type="checkbox"/> Help with rent/food/clothing |
| <input type="checkbox"/> Cash aid | <input type="checkbox"/> Gift of money | <input type="checkbox"/> Insurance or legal settlements |
| <input type="checkbox"/> CalWORKs/TANF/GA/GR/CAP | <input type="checkbox"/> Unemployment Insurance/State Disability Insurance (SDI) | <input type="checkbox"/> Private disability or retirement |
| <input type="checkbox"/> Room and board (from your renter) | <input type="checkbox"/> Worker's compensation | <input type="checkbox"/> Strike benefits |
| <input type="checkbox"/> Pension | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Child/Spousal support | | |
| <input type="checkbox"/> Government/railroad disability or retirement | | |

Person getting the money?	From where?	How much?	How often received? (Once, weekly, monthly, or other)	Expect to continue? (✓ Check Yes or No)
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

If this income is not expected to continue, please explain:

8. EARNED INCOME

Do you or anyone you buy and prepare food with get income from a job (earned income)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the question 9.

NOTE: If self-employed fill out question 8a.

Please list all income **before** taxes or other deductions are taken out (gross income).

Examples of earned income are (these examples can be full-time, temporary, seasonal, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)

Person working	Employer's name and address	Employer's phone number	Hourly rate	Average hours per week	How often paid? (Once, weekly, monthly, or other)	Total gross earned income received this month	Expect to continue? (✓ Check Yes or No)
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

If this income is not expected to continue, please explain:

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? (Please Check One) ☐ Yes ☐ No

IF YES, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY
REASON?		

Is anyone on strike? (Please Check One) ☐ Yes ☐ No

IF YES, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY
REASON?		

8a. SELF-EMPLOYMENT

Self-employed household members may deduct actual self-employment expenses or take a standard 40% deduction off of self-employment income. If you choose actual expenses, you will need to give the County proof of the expenses.

Person self-employed	Date business started	Type of business and name	Gross monthly income	Self-employment expenses (Please ✓ check one)
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$ _____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$ _____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$ _____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$ _____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$ _____

9. HOUSEHOLD'S CHILD/ADULT CARE EXPENSES

Do you or anyone you buy and prepare food with pay for the care of a child, disabled adult, or other dependent so you or the other person can go to work, school, training, or look for a job? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

Who gets care?	Who gives care? (Name and address of provider)	Amount paid?	How often paid? (Weekly/monthly, other)
		\$	
		\$	
		\$	
		\$	

Does anyone help your household pay all or part of your child/adult care costs listed above? ☐ Yes ☐ No If **yes**, complete below:

Who gets care?	Who helps pay?	Amount paid?	How often paid? (Weekly/monthly, other)
		\$	
		\$	

10. CHILD SUPPORT PAYMENTS

Are you or anyone you buy and prepare food with legally obligated to pay child support, including back child support?
☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How often paid? (Weekly/monthly, other)
		\$	
		\$	

11. HOUSEHOLD EXPENSES

Are you or anyone you buy and prepare food with responsible for any household expenses? ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

NOTE: Do not enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances and you do not need to fill in the actual amount owed.

Type of expenses	Have expense? (Please Check One)	Who pays?	Amount owed	How often billed (weekly/monthly, other)
Rent or house payment	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Property taxes and insurance (if billed separately from rent or mortgage)	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if billed separately from rent or mortgage)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Telephone/cell phone	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Homeless Shelter Expense	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Water, sewage, garbage	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does anyone <u>not</u> in your household help you pay for the expenses listed above? (Please Check One) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please complete.		Who helps pay?	How much? \$	How often paid?

Does your household receive, or expect to receive, payment from the Low Income Home Energy Assistance Program (LIHEAP)?
(Please Check One) ☐ Yes ☐ No

12. MEDICAL EXPENSES:

Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

List expenses you expect to have in the near future.

Allowable medical expenses are: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Medical or dental care | <input type="checkbox"/> Medicare premiums (Medi-Cal share of costs, etc.) | <input type="checkbox"/> Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services |
| <input type="checkbox"/> Hospitalization/outpatient treatment/nursing care | <input type="checkbox"/> Dentures, hearing aids and prosthetics | <input type="checkbox"/> Prescribed eye glasses and contact lenses |
| <input type="checkbox"/> Prescribed medications | <input type="checkbox"/> Maintaining an attendant necessary due to age, illness, or infirmity | <input type="checkbox"/> Prescribed medical supplies and equipment |
| <input type="checkbox"/> Health and Hospitalization insurance policy premiums | <input type="checkbox"/> The number and cost of meals furnished to an attendant | <input type="checkbox"/> Service animals expenses (food, vet bills, etc.) |
| | <input type="checkbox"/> Prescribed over the counter medications | |

Name of elderly/disabled person	Amount of expense	How often paid? (Weekly/monthly, other)	What type of expense? (Prescriptions, dentures, number of meals for attendant, etc.)	Will the household be reimbursed for any medical expenses? (By Medi-Cal, insurance, family member, etc.)
	\$			IF YES, BY WHO: HOW MUCH: \$
	\$			IF YES, BY WHO: HOW MUCH: \$
	\$			IF YES, BY WHO: HOW MUCH: \$
	\$			IF YES, BY WHO: HOW MUCH: \$

13. Does anyone who is applying for benefits, including you, get food from any of the following? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Communal dining facility for the elderly/disabled
- Food distribution program operated by a Native American reservation
- Other food program

IF YES, WHO?	WHERE?
IF YES, WHO?	WHERE?

14. Does anyone who is applying for benefits, including you, live at any of the following? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution (*Jail or Prison*)
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

Person's Name	Name of Institution (center, shelter, facility, etc.)	Expected Date of Release (If applicable)

15. Are you or anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? (Please Check One) ☐ Yes ☐ No

IF YES, WHO?

16. HOUSEHOLD'S RESOURCES

Do you or anyone you buy and prepare food with have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? ☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

Check all that apply:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Bank/Credit Union account (Checking) | <input type="checkbox"/> Money Market Account | <input type="checkbox"/> Stocks |
| <input type="checkbox"/> Bank/Credit Union account (Saving) | <input type="checkbox"/> Mutual Funds | <input type="checkbox"/> Bonds |
| <input type="checkbox"/> Safe Deposit box | <input type="checkbox"/> Certificate of Deposit (CD) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Savings Bond(s) | <input type="checkbox"/> Cash on hand | |

If joint account with another person please say so below.

For each box checked above, complete the following information.

In whose name is the resource listed?	What type of resource?	How much is it worth?	Where is the resource? (Include the name of the bank or company where money is held)
		\$	
		\$	
		\$	
		\$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months?

(Please Check One) ☐ Yes ☐ No

17. DUPLICATE BENEFITS

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program, known as CalFresh in California) benefits in any state after September 22, 1996? (Please Check One)

☐ Yes ☐ No

If **yes**, who? _____

18. TRAFFICKING (TRADING OR SELLING) OF BENEFITS

Have you or any member of your household ever been convicted of trafficking (trading or selling EBT cards to others) SNAP benefits of \$500 or more after September 22, 1996? (Please Check One)

☐ Yes ☐ No

If **yes**, who? _____

19. TRADING BENEFITS FOR DRUGS

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? (Please Check One)

☐ Yes ☐ No

If **yes**, who? _____

20. TRADING BENEFITS FOR FIREARMS OR EXPLOSIVES

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition, or explosives after September 22, 1996? (Please Check One)

☐ Yes ☐ No

If **yes**, who? _____

21. FLEEING FELON

Are you or any member of your 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? (Please Check One)

☐ Yes ☐ No

If **yes**, who? _____

22. PROBATION/PAROLE VIOLATION

Have you or any member of your household been found by a court of law to be in violation of probation or parole? (Please Check One)

☐ Yes ☐ No

If **yes**, who? _____

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY**IF THE ANSWER IS YES TO ANY OF THE QUESTIONS BELOW - EXPEDITE**

Is the household's gross income less than \$150 and cash on hand, or in checking and savings accounts \$100 or less?

☐ Yes ☐ No

Is the household's combined gross income and cash on hand or on checking and savings accounts less than the combined rent/mortgage and appropriate utility allowance?

☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding \$100 and does not expect to receive more than \$25 in next 10 days?

☐ Yes ☐ No



APPLICATION FOR CALFRESH BENEFITS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?

Use this application if you are applying for CalFresh benefits only. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you wish to apply for programs other than CalFresh such as, CalWORKs or Medi-Cal, please ask for an application to apply for other programs. You can also apply for CalFresh or other programs online by going to <http://www.benefitscal.org/>.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1) to begin the application process.

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- Give the application to the County in person, by mail, by fax, or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?

- Read about your rights and your responsibilities (Program Rules pages 1 through 5) before you sign the application.
- You must have an interview with the County to discuss your application. Most interviews are done by phone, but it can be done in person at the County office or other place arranged with the County. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?

It may take up to 30 days to process your application. You may be able to get benefits within 3 calendar days, if you meet one of the Expedited Service criteria:

- Your household's monthly gross income (income before

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California Department of Social Services

deductions) is less than \$150 and your cash on hand or in checking or savings accounts is \$100 or less; or

- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and cash on hand or in checking or savings accounts; or
- You are a migrant or seasonal farmworker household with less than \$100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than \$25 in the next 10 days.

To help the County see if you can get benefits in three days, please answer questions 1, 6 through 8, 11, and 16, and give the County proof of your identify (if you have it) with the application.

The County will send you a letter to let you know if your household is approved or denied CalFresh benefits.

Agency Conference

Agency conference is a process that provides the household the right to request a meeting with an eligibility supervisor (this meeting may be attended by an eligibility worker and an authorized representative) to informally resolve any dispute as to whether the household meets Expedited Service criteria.

The agency conference shall be scheduled within two working days of the request, unless the household requests

that it be scheduled later or states that they do not wish to have an agency conference.

What do I need for my interview?

To avoid delays, bring proof of the following with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get CalFresh benefits and the amount of benefits you can get.

Proof Needed to Get Benefits

- Identification (Driver's License, State ID card, passport).
- Where you live (a rental agreement, current bill with your address listed).
- Social Security Numbers (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expense or tax records.

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- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for noncitizens applying for benefits (an Alien Registration Card, visa).

NOTE: Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security Number.

Proof Needed to Get More CalFresh Benefits

- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

How do I get/use my CalFresh benefits?

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to use your card.
- If your EBT card is lost, stolen, or destroyed, or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County right away. Make sure all responsible adults and your authorized representative also know how to report one of these problems right away. If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will not be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. For a list of locations near you that accept EBT please go to: <https://www.ebt.ca.gov>.

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- CalFresh benefits are only for you and your household members. Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.

What if I am homeless?

Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh, homeless means you are:

- A. Staying in a supervised shelter, halfway house, or similar place.
- B. Staying at the home of another person or family for no more than 90 days straight.
- C. Sleeping in a place not designed for, or normally used as, a place to sleep (e.g., a hallway, a bus station, a lobby, or similar places).

Informational Page
Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. If you don't meet your household's reporting requirements your case will be closed or your CalFresh benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with County, State, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any CalFresh benefits that you were not eligible to get.

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You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application for CalFresh and get an explanation of the rules.
- Ask for help to get proof that is needed.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days.

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- Get at least 10 days to give the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your CalFresh case. If you ask for a hearing before an action on your CalFresh case takes place, your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any over paid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone number – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349**. You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.

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- Get assistance from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh benefits that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive.

Please take and keep for your records

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**Program Violations
For CalFresh: I
understand I may have
committed an intentional
program violation if I do
any of the following:**

- Hide information or make false statements
- Use Electronic Benefit Transfer (EBT) cards that belong to someone else or let someone else use my card
- Use CalFresh benefits to buy alcohol or tobacco
- Trade, buy, sell, steal or give away CalFresh benefits or EBT cards, or attempt to trade, buy, sell, steal or give away CalFresh benefits or EBT cards
- Try to get dual benefits, for example, apply in two or more different counties or states at the same time

**Penalties
I may:**

- Lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me
- Lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me

Please take and keep for your records

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**Program Violations
For CalFresh: I
understand I may have
committed an intentional
program violation if I do
any of the following:
(Continued)**

- Submit false documents for children or adult household members who are not eligible or who do not exist
- Violate conditions of my probation or parole
- Flee after a felony conviction
- Purchase (buy) a product with CalFresh benefits that has a return deposit, intentionally (on purpose) throw away the contents and return the container for the deposit amount or attempt to return the container for the deposit amount

**Penalties
I may: (Continued)**

- Lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me

Please take and keep for your records

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**Program Violations
For CalFresh: I
understand I may have
committed an intentional
program violation if I do
any of the following:
(Continued)**

- Buy a product with CalFresh benefits and intentionally resell it for cash or anything other than eligible food

- Trade CalFresh benefits or attempt to trade CalFresh benefits for: cash, firearms, non-eligible goods or controlled substances such as drugs

- Give false information about who I am and where I live so I can get extra CalFresh benefits

**Penalties
I may: (Continued)**

- Be fined up to \$250,000.00, imprisoned up to 20 years or both

- Lose CalFresh benefits for 24 months for the first offense
- Lose CalFresh benefits permanently for the second offense

- Lose CalFresh benefits for 10 years for each offense

Please take and keep for your records

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**Program Violations
For CalFresh: I
understand I may have
committed an intentional
program violation if I do
any of the following:
(Continued)**

- Have been convicted of trading, selling or attempting to trade CalFresh benefits worth more than \$500, or trading or attempting to trade CalFresh benefits for firearms, ammunition or explosives

**Penalties
I may: (Continued)**

- Lose CalFresh benefits permanently

Important Information for Noncitizens

- You can apply for and get CalFresh benefits for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.

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- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for CalFresh benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for CalFresh benefits.

Privacy Act and Disclosure: You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the requested information, the County may deny your application. You have the right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law

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allows them to do so. 273.2(b)(4) *Privacy Act statement*. As a County agency, we must notify all households applying and being recertified for CalFresh benefits of the following:

- (i) The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the CalFresh Program. We will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will also be used to monitor compliance with program regulations and for program management.
- (ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- (iii) If a CalFresh claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

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(iv) Providing the requested information including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of CalFresh benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will check your answers using information in state and federal electronic databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a **consumer reporting agency**. If the information does not match, the County may ask you to send proof.

Use of Social Security Numbers (SSN)

Everyone applying for CalFresh benefits needs to provide a SSN, if they have one, or proof that they have applied for a SSN (such as a letter from the Social Security Office). The County may deny CalFresh benefits for you or any member of your household who does not give us a SSN. Some people do not have to give SSN's to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.

Please take and keep for your records

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the County made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting

Every household that gets CalFresh benefits must report certain changes. Your County will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your CalFresh benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearing

You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request a State hearing. If you ask for a hearing before the action happens, you may be able to keep your CalFresh benefits the same until a decision is made.

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Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD 3027) found online at <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint> and at any USDA office, or contact your County's Civil Rights Coordinator, or write a letter addressed to USDA and provide in the letter all of the information requested in the form or write to California

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Department of Social Services (CDSS) address below. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410

CDSS
Civil Rights Bureau
P.O.BOX 944243, M.S. 9-7-041
Sacramento, CA 94244-2430
1-866-741-6241 (Toll Free)

(2) fax: USDA (202) 690-7442, CDSS (916) 651-0602; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

Case File Reviews

Your case may be selected for additional review to ensure that your eligibility was correctly figured. You must cooperate fully with the County, State, or federal personnel in any investigation or review, including a quality control review. Failure to cooperate in these reviews could result in loss of your benefits.

Please take and keep for your records

Work Rules for CalFresh

The County may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped. You may not be eligible for CalFresh if you have recently quit a job without a good reason.

EBT Usage

Any benefit taken from your account before you, another household member, or your authorized representative report the EBT card or PIN has been lost or stolen will **not** be replaced.

Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **not** be replaced.

If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will **not** be replaced.

Please take and keep for your records

NOTES

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Please use black or blue ink because it is easy to read and copies best. Please print your answers. If you need more space to answer a question(s), use page 10 “Additional Writing Space” section and attach additional sheets of paper if needed to provide the information. Please be sure to identify which question you are writing about in the extra space or on the additional sheets of paper.

1. Applicant's Information

Name (first, middle, last)	Other Names (maiden, nicknames, etc.)	Social Security Number (if you have one and <u>are</u> applying for benefits)	
Home Address or Directions to Your Home	City	State	Zip Code
Mailing Address (if different from above)	City	State	Zip Code

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CONTACT AUTHORIZATION

Please give the county the best contact information to reach you. This will help in processing your application. By providing your contact information below, you are authorizing the county to contact you by phone, email or text, or to leave a phone message regarding your application.

Home Phone	Cell Phone	Check Box for Text <input type="checkbox"/>
Work/Alternative/Message Phone	Email Address	

Are you homeless? ☐ Yes ☐ No If **yes**, please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)? _____

What language do you prefer to speak (if not English)? _____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here. ☐

Do you or anyone in your household have a disability (optional question)? (Please Check One) ☐ Yes ☐ No

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(Please Check One)

Do you or anyone in your household need an accommodation due to a disability (optional question)?

☐ Yes ☐ No

Has there been a history of domestic violence/abuse (optional question)?

☐ Yes ☐ No

Are you interested in applying for Medi-Cal? If you answer **yes**, the County will use your answers to find out if you can get Medi-Cal.

☐ Yes ☐ No

Is your household's monthly gross income less than \$150 and cash on hand, or in checking and savings accounts is \$100 or less?

☐ Yes ☐ No

Is your household's combined monthly gross income and cash on hand or in checking and savings accounts less than the combined cost of rent/mortgage and utilities?

☐ Yes ☐ No

Is your household a migrant/seasonal farm worker household with liquid resources not exceeding \$100 and either your income stopped or you will not get more than \$25 in the next 10 days?

☐ Yes ☐ No

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers

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to the questions in this application.

- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Pages 1-4) for the CalFresh Program.
- I read, or had read to me, the CalFresh Program Rules and Penalties (Program Rules Pages 4-8).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility for CalFresh is fraud. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits.
- I understand that Social Security Numbers or immigration status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.

Signature of Applicant (or Adult Household Member/Authorized Representative*/Guardian)	Date
--	------

***If you have an Authorized Representative please complete question 2.**

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2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE:

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case?

(Please Check One) ☐ Yes ☐ No If **yes**, complete the following section:

Authorized Representative Name	Authorized Representative Phone Number
--------------------------------	--

Do you want to name someone to receive and spend CalFresh benefits for your household? (Please Check One)

☐ Yes ☐ No

If **yes**, complete the following section:

Name		Phone Number	
Street Address	City	State	Zip Code

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3. RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

- ☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	Are you Hispanic or Latino? (Please Check One) <input type="checkbox"/> Yes <input type="checkbox"/> No
	If you are of Hispanic or Latino origin, do you consider yourself: <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other_____

RACE/ETHNIC ORIGIN

- ☐ White ☐ American Indian or Alaskan Native ☐ Black or African American
- ☐ Other or Mixed _____
- ☐ Asian (If checked, please select one or more of the following):
- ☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese
- ☐ Asian Indian ☐ Laotian ☐ Other Asian (specify) _____

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RACE/ETHNIC ORIGIN - Continued

- ☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following):
- ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
-

4. Interview Preference

You or another adult member in your household will need to have an interview with the County to discuss your application and to receive CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. In-person interviews will only happen during the County's normal office hours.

- ☐ Please check this box if you would prefer an in-person interview.
- ☐ Please check this box if you need other arrangements due to a disability.

Please check the boxes below for your preferred day and time for an interview:

Day: ☐ Today ☐ Next available day ☐ Any day ☐ Monday ☐ Tuesday
☐ Wednesday ☐ Thursday ☐ Friday

Time: ☐ Early morning ☐ Mid-morning ☐ Afternoon ☐ Late afternoon ☐ Anytime

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5. OTHER PROGRAMS

Have you or anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Medicaid, Supplemental Nutrition Assistance Program [CalFresh], General Assistance (GA)/General Relief (GR), etc.)? (Please Check One) ☐ Yes ☐ No

If **yes**, who?

Where (county/state)?

If **yes**, who?

Where (county/state)?

6a. Household's Information

Complete the following information for all persons in the home that you buy and prepare food with, including you. **If applying for noncitizens, please complete question 6b and 6c. If not, go to question 6d.**

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Social Security number is optional for members not applying for benefits. You must answer the questions below for each person applying for benefits.

Social Security Number	U.S. Citizen or National (✓) Check Yes or No If no, complete question 6b	Gender (M or F)	Date of birth	How is the person related to you?	Name (Last, First, Middle Initial)	Applying for benefits (✓) check Yes or No
	<input type="checkbox"/> Yes <input type="checkbox"/> No			SELF		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No

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Please list the names of anyone who lives with you that does not buy and prepare food with you:

Name	Name
Name	Name

6b. NONCITIZEN INFORMATION - Complete for those listed in question 6a who are not citizens and are applying for aid.

Name	Date of Entry into U.S. (If known)	Give one of the following (If known): Passport Number, Alien Registration Number, etc.	Sponsored? (✓ Check Yes or No) If yes , complete question 6c:
		Document Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Document Number:	
		Document Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Document Number:	
		Document Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Document Number:	

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(Please Check One)

Does anyone listed above have at least 10 years (40 quarters) of work history or military service in the USA? ☐ Yes ☐ No

If **yes**, who? _____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa, U-Visa or VAWA status? ☐ Yes ☐ No

If **yes**, who? _____

6c. SPONSORED NONCITIZEN INFORMATION - Complete for those listed in question 6b above who are sponsored noncitizens and are applying for aid.

Did the sponsor sign an I-864? ☐ Yes ☐ No

If **yes**, please answer the rest of the question. If the sponsor signed an I-134 then skip this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No

If **yes**, how much? \$ _____

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Does the sponsor regularly help with any of the following (check all that apply)?

☐ rent ☐ clothes ☐ food ☐ other _____

Sponsor's Name	Who is sponsored?	Sponsor's Phone Number
Sponsor's Name	Who is sponsored?	Sponsor's Phone Number

6d. STUDENTS

Is anyone who is applying for benefits including you attending a college or vocational school? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Name of person	Name of school/ training	Enrolled status (✓ Check one)	Are they working?
		<input type="checkbox"/> Half-time or more <input type="checkbox"/> Less than half-time Number of units: _____	Average work hours per week: _____
		<input type="checkbox"/> Half-time or more <input type="checkbox"/> Less than half-time Number of units: _____	Average work hours per week: _____

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6e. Is there a foster child living in your home? (Please Check One)
☐ Yes ☐ No

If **yes**, who? _____

Please answer the following questions about the child(ren):

Was this child(ren) placed in your home under a dependence order of the court? ☐ Yes ☐ No

Do you want the foster care child(ren) counted in your CalFresh case? ☐ Yes ☐ No

If **yes**, the foster care income you receive will be counted as unearned income.

If **no**, the foster care income will not be counted as unearned income.

7. Unearned Income

Do you or anyone you buy and prepare food with get income that does not come from a job (unearned)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

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Check all types of unearned income that apply from these examples (there may be others not listed here):

- | | |
|---|--|
| <input type="checkbox"/> Social Security | loans/scholarships) |
| <input type="checkbox"/> SSI/SSP | <input type="checkbox"/> Gift of money |
| <input type="checkbox"/> Cash aid | <input type="checkbox"/> Unemployment Insurance/State Disability Insurance (SDI) |
| <input type="checkbox"/> CalWORKs/TANF/GA/GR/CAPI | <input type="checkbox"/> Worker's compensation |
| <input type="checkbox"/> Room and board (from your renter) | <input type="checkbox"/> Lottery/gambling winnings |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Help with rent/food/clothing |
| <input type="checkbox"/> Child/Spousal support | <input type="checkbox"/> Insurance or legal settlements |
| <input type="checkbox"/> Government/railroad disability or retirement | <input type="checkbox"/> Private disability or retirement |
| <input type="checkbox"/> Veteran benefits, or Military pension | <input type="checkbox"/> Strike benefits |
| <input type="checkbox"/> Financial aid (school grants/ | <input type="checkbox"/> Other _____ |

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Person getting the money	From where?	How much?	How often received? (Once, weekly, monthly, or other)	Expect to continue? (✓ Check Yes or No)
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

If this income is not expected to continue, please explain:

8. EARNED INCOME

Do you or anyone you buy and prepare food with get income from a job (earned income)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the question 9.

NOTE: If self-employed fill out question 8a.

Please list all income **before** taxes or other deductions are taken out (gross income).

Examples of earned income are (these examples can be full-time, temporary, seasonal, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)

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Person working	Employer's name and address	Employer's phone number	Hourly rate	Average hours per week	How often paid? (Once, weekly, monthly, other)	Total gross earned income received this month	Expect to continue? (✓ Check Yes or No)
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

If this income is not expected to continue, please explain:

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Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? (Please Check One) ☐ Yes ☐ No

If yes , who?	Date of job loss, quit, or change	Date of last pay
Reason?		

Is anyone on strike? (Please Check One) ☐ Yes ☐ No

If yes , who?	Date went on strike	Date of last pay
Reason?		

8a. SELF-EMPLOYMENT

Self-employed household members may deduct actual self-employment expenses or take a standard 40% deduction off of self-employment income. If you choose actual expenses, you will need to give the County proof of the expenses.

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Person self-employed	Date business started	Type of business and name	Gross monthly income	Self-employment expenses (Please ✓ check one)
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$_____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$_____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$_____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$_____
			\$	<input type="checkbox"/> 40% flat rate <input type="checkbox"/> Actual expenses \$_____

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9. HOUSEHOLD'S CHILD/ADULT CARE EXPENSES

Do you or anyone you buy and prepare food with pay for the care of a child, disabled adult, or other dependent so you or the other person can go to work, school, training, or look for a job? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Who gets care?	Who gives care? (Name and address of provider)	Amount paid?	How often paid? (Weekly/ monthly, other)
		\$	
		\$	
		\$	
		\$	

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Does anyone help your household pay all or part of your child/adult care costs listed above? ☐ Yes ☐ No

If **yes**, complete below:

Who gets care?	Who helps pay?	Amount paid?	How often paid? (Weekly/ monthly, other)
		\$	
		\$	

10. CHILD SUPPORT PAYMENTS

Are you or anyone you buy and prepare food with legally obligated to pay child support, including back child support? ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

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Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How often paid? (Weekly/monthly, other)
		\$	
		\$	

11. HOUSEHOLD EXPENSES

Are you or anyone you buy and prepare food with responsible for any household expenses? ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

NOTE: Do not enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances and you do not need to fill in the actual amount owed.

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Type of expenses	Have expense? (Please Check One)	Who pays?	Amount owed	How often billed? (Weekly/monthly, other)
Rent or house payment	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Property taxes and insurance (if billed separately from rent or mortgage)	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if billed separately from rent or mortgage)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Telephone/cell phone	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Homeless Shelter Expense	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Water, sewage, garbage	<input type="checkbox"/> Yes <input type="checkbox"/> No			

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Does anyone <u>not</u> in your household help you pay for the expenses listed above? (Please Check One) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please complete.	Who helps pay?	How much? \$	How often paid?
--	-----------------------	------------------------	------------------------

Does your household receive, or expect to receive, payment from the Low Income Home Energy Assistance Program (LIHEAP)? (Please Check One)
☐ Yes ☐ No

12. MEDICAL EXPENSES

Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

List expenses you expect to have in the near future.

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Allowable medical expenses are: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Medical or dental care | <input type="checkbox"/> The number and cost of meals furnished to an attendant |
| <input type="checkbox"/> Hospitalization/outpatient treatment/nursing care | <input type="checkbox"/> Prescribed over the counter medications |
| <input type="checkbox"/> Prescribed medications | <input type="checkbox"/> Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services |
| <input type="checkbox"/> Health and Hospitalization insurance policy premiums | <input type="checkbox"/> Prescribed eye glasses and contact lenses |
| <input type="checkbox"/> Medicare premiums (Medi-Cal share of costs, etc.) | <input type="checkbox"/> Prescribed medical supplies and equipment |
| <input type="checkbox"/> Dentures, hearing aids and prosthetics | <input type="checkbox"/> Service animals expenses (food, vet bills, etc.) |
| <input type="checkbox"/> Maintaining an attendant necessary due to age, illness, or infirmity | |

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Name of elderly/ disabled person	Amount of expense	How often paid? (Weekly/monthly, other)	What type of expense? (Prescriptions, dentures, number of meals for attendant, etc.)	Will the household be reimbursed for any medical expenses? (By Medi-Cal, insurance, family member, etc.)
	\$			If yes , by who: How much: \$
	\$			If yes , by who: How much: \$
	\$			If yes , by who: How much: \$
	\$			If yes , by who: How much: \$

13. Does anyone who is applying for benefits, including you, get food from any of the following? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

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- Communal dining facility for the elderly/disabled
- Food distribution program operated by a Native American reservation
- Other food program

If **yes**, who?

Where?

If **yes**, who?

Where?

14. Does anyone who is applying for benefits, including you, live at any of the following? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution (*Jail or Prison*)
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

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Person's Name	Name of Institution (Center, shelter, facility, etc.)	Expected Date of Release (If applicable)

15. Are you or anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?

(Please Check One) ☐ Yes ☐ No

If **yes**, who? _____

16. HOUSEHOLD'S RESOURCES

Do you or anyone you buy and prepare food with have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)?

☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

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Check all that apply:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Bank/Credit Union account (Checking) | <input type="checkbox"/> Savings Bond(s) | <input type="checkbox"/> Cash on hand |
| <input type="checkbox"/> Bank/Credit Union account (Saving) | <input type="checkbox"/> Money Market Account | <input type="checkbox"/> Stocks |
| <input type="checkbox"/> Safe Deposit box | <input type="checkbox"/> Mutual Funds | <input type="checkbox"/> Bonds |
| | <input type="checkbox"/> Certificate of Deposit (CD) | <input type="checkbox"/> Other: _____ |

If joint account with another person please say so below.

For each box checked above, complete the following information.

In whose name is the resource listed?	What type of resource?	How much is it worth?	Where is the resource? (Include the name of the bank or company where money is held)
		\$	
		\$	
		\$	
		\$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months? (Please Check One) ☐ Yes ☐ No

17. DUPLICATE BENEFITS

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program, known as CalFresh in California) benefits in any state after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who? _____

18. TRAFFICKING (TRADING OR SELLING) OF BENEFITS

Have you or any member of your household ever been convicted of trafficking (trading or selling EBT cards to others) SNAP benefits of \$500 or more after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who? _____

19. TRADING BENEFITS FOR DRUGS

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? (Please Check One)
☐ Yes ☐ No

If **yes**, who? _____

20. TRADING BENEFITS FOR FIREARMS OR EXPLOSIVES

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition, or explosives after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who? _____

21. FLEEING FELON

Are you or any member of your 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? (Please Check One) ☐ Yes ☐ No

If **yes**, who? _____

22. PROBATION/PAROLE VIOLATION

Have you or any member of your household been found by a court of law to be in violation of probation or parole? (Please Check One) ☐ Yes ☐ No

If **yes**, who? _____

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

IF THE ANSWER IS YES TO ANY OF THE QUESTIONS BELOW - EXPEDITE

Is the household's gross income less than \$150 and cash on hand, or in checking and savings accounts \$100 or less? ☐ Yes ☐ No

Is the household's combined gross income and cash on hand or on checking and savings accounts less than the combined rent/mortgage and appropriate utility allowance? ☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding \$100 and does not expect to receive more than \$25 in next 10 days? ☐ Yes ☐ No

INFORMATION FOR HOUSEHOLDS APPLYING FOR CALFRESH WITH THE SOCIAL SECURITY ADMINISTRATION



YOU APPLIED FOR CALFRESH. WHAT'S NEXT?

You completed your CalFresh application with the help of the Social Security Administration (SSA). Here's what will happen next:

- Your local County social services office will process your CalFresh application and make a CalFresh eligibility decision.
- Your County may contact you by mail or by phone to get more information to process your application.

Important: If contacted by phone, the County caller ID for the phone call may come from a "Private," "Unknown," or "County" phone number. Please be sure to answer any calls with these caller IDs for the next 30 days.
- Your County will make an eligibility decision within 30 days of the date you completed your CalFresh application with the help of SSA. If you do not hear from your County within 30 days, contact them.

HOW TO CONTACT YOUR COUNTY SOCIAL SERVICES OFFICE

If you need to contact your County social services office for any reason, here's how you can do that:

- Call **(877) 847-3663** and enter your ZIP code to be connected to your County by phone. This service is available in English, Spanish, Cantonese, Vietnamese, Korean, and Russian. For speech and/or hearing assistance call 7-1-1 Relay.
- Find your local County office at <https://www.calfreshfood.org/>. Choose the "Come In" option and click on the "Find your County office here" link. Once you enter your address, a map will show you the closest County office and give you the office address, phone number, and hours of operation.

If you need any help, a **reasonable accommodation**, or **language services**, please request this from your County.

If you want a copy of your CalFresh application, please request this from your County.

HOW TO USE YOUR ELECTRONIC BENEFITS TRANSFER (EBT) CARD

- If your CalFresh application is approved, the County will mail you an EBT card or if you choose, you can come into your County office to pick one up. You can buy groceries with the EBT card.
- When you get your EBT card, sign it. You will also need to set-up a Personal Identification

Number (PIN) to use your EBT card. **Do not give out your PIN number** or keep it with your EBT card. Your County will never ask you for your PIN number.

- If your EBT card is lost, stolen, or destroyed, call (877) 328-9677 or call your County right away. If you think someone knows your PIN and you don't want that person to use your CalFresh benefits, call (877) 328-9677 or call your County right away.
- You can use your EBT card at most grocery stores and some farmer's markets. You cannot use your CalFresh benefits to buy alcohol, tobacco, pet food, some types of hot and prepared foods, or anything that is not food (like toothpaste, soap, or paper towels).

HOW TO KEEP YOUR CALFRESH BENEFITS

There are certain steps you need to take to keep your CalFresh benefits.

1. Report when your income increases and goes over the "Income Reporting Threshold (IRT)"

- a. Your monthly gross income is the amount of money your household receives before taxes.
- b. Your County will tell you your household IRT when your CalFresh application is approved.
- c. Any time your household's gross monthly income goes over the IRT, you must report the new gross monthly income to your County within 10-days of getting it.

My household IRT is: _____

2. Complete and submit your periodic report (SAR 7) on time

- a. A SAR 7 is a CalFresh report you must use to provide your County an update on your household's information (income, number of people living in the home, expenses, change of address, etc.)
- b. Your County will mail you a SAR 7 form and it will tell you the due date.
- c. You must complete and submit your SAR 7 by the due date. If you are reporting changes, you may need to provide proof. Tell your County if you need help providing proof.

My periodic report (SAR 7) due date is: _____

3. Complete and submit your recertification application (CF 37) on time

- a. A CF 37 is a recertification application you must use to make sure you still qualify for CalFresh. You must tell your County information about your household.
- b. Your County will mail you a recertification application packet or appointment letter and it will tell you the due date.
- c. You must complete and submit your recertification application by the due date. You may need to provide proof. Tell your County if you need help providing proof.

My recertification application (CF 37) due date is: _____

KNOW YOUR RIGHTS AND RESPONSIBILITIES

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Have an interpreter provided at no cost if you need one.
- Ask for help to fill out your application, ask for an explanation of the rules, or ask for help to get proof that is needed.
- Let the County know if you would like someone else to use your benefits for you or help with your CalFresh case (Authorized Representative).
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Get at least 10 days to give the County proof that is needed to make a determination of eligibility.
- Give proof of your household's expenses that may help you get more benefits. Not giving proof to the County is the same as saying that you do not have the expense and you will not be able to get more benefits.
- Withdraw your application at any time prior to the County determining eligibility.
- Get written notice at least 10 days before the County lowers or stops your benefits.
- Discuss and review your case with the County when you ask to do so.
- Report changes that you are not required to report, if doing so may increase your benefits.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Ask for a State hearing within 90 days if you do not agree with the County about your CalFresh case. If you ask for a hearing before an action on your CalFresh case takes place, your CalFresh benefit will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefit change until after the hearing to avoid having to pay back any overpaid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that are owed to you.
- Ask about your hearing rights or for legal aid referral at the toll-free phone number – (800) 952-5253 – or for hearing or speech impaired who use TDD (800) 952-8349. You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you don't want to go alone.
- Get assistance from the County to register to vote.

You have the responsibility to:

- Give the County all the information needed to determine your eligibility.
- Give the County proof of the information when needed.
- Report changes as required. The County will give you information about what, when, and how to report. If you don't meet your reporting requirements, your case may be closed, or your benefits may be lowered or stopped.
- Fully cooperate with County, State, or Federal personnel if your case is selected for review. The review is to ensure that your eligibility and benefit level is correct and failure to cooperate will result in a loss of your benefits.
- Pay back any benefits that you were not eligible to get.

DISCRIMINATION PROHIBITION AND COMPLAINT PROCESS

In accordance with Federal civil rights law and the U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, USDA Agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.) should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD 3027) found online at <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or contact your County's Civil Rights Coordinator, or write a letter addressed to USDA and provide in the letter all the information requested in the form or write to the California Department of Social Services (CDSS) address below. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410

CDSS, Civil Rights Bureau
P.O. Box 944243, M.S. 9-7-041
Sacramento, CA 94244-2430
(866) 741-6241 (toll free)

(2) Fax: USDA (202) 690-7442, CDSS (916) 651-0602

(3) Email: program.intake@usda.gov

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If you want information about or need assistance registering to vote, contact your County social services office.

MORE INFORMATION ABOUT GETCALFRESH.ORG

If your SSA technician helped you apply for CalFresh using the GetCalFresh.org application assistance tool, you can get more information about GetCalFresh.org at: <https://www.getcalfresh.org/>.

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State of California – Health and Human Services Agency
California Department of Social Services

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State of California – Health and Human Services Agency
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- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410

CDSS, Civil Rights Bureau
P.O. Box 944243, M.S. 9-7-041
Sacramento, CA 94244-2430
(866) 741-6241 (toll free)
- (2) Fax: USDA (202) 690-7442, CDSS (916) 651-0602
- (3) Email: program.intake@usda.gov

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