

May 14, 2025

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

ALL COUNTY LETTER NO. 25-34

The purpose of this All County Letter is to release two new optional CalFresh forms: the CalFresh Medical Certification Form (CF 887) and the CalFresh Able-Bodied Adults Without Dependents Volunteer Work Hours Verification Form (CF 888).



JENNIFER TROIA
DIRECTOR

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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GAVIN NEWSOM
GOVERNOR

May 14, 2025

ALL COUNTY LETTER NO. 25-34

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CONSORTIA REPRESENTATIVES
ALL QUALITY CONTROL COORDINATORS

SUBJECT: CALFRESH FORMS TO VERIFY VOLUNTEER WORK HOURS
AND UNFITNESS TO WORK

REFERENCE: [TITLE 7 OF THE CODE OF FEDERAL REGULATIONS \(CFR\)
PART 273.24; 7 CFR 273.5; 7 CFR 273.7; ALL COUNTY LETTER
\(ACL\) NUMBER \(NO.\) 19-93; ACL NO. 20-08; ACL NO. 22-20](#)

The purpose of this All County Letter (ACL) is to release two new optional CalFresh forms: the CalFresh Medical Certification Form (CF 887) and the CalFresh Able-Bodied Adults Without Dependents (ABAWD) Volunteer Work Hours Verification Form (CF 888).

CalFresh Medical Certification Form (CF 887)

The CF 887 is a new optional form developed to verify an individual's physical or mental unfitness to work when it is not obvious or is considered questionable. This form may be used for purposes of determining exemptions from the ABAWD time limit, work registration, or the student eligibility rule.

Because this form authorizes the release of sensitive medical and personally identifiable information, the County Welfare Department (CWD) must ensure existing protocols are applied to maintain confidentiality.

Section 1 of the CF 887 must be completed by the CalFresh applicant or participant whose personal health information is being requested. This section allows the participant to authorize the release of their medical information for purposes of determining eligibility for CalFresh. The participant authorizing the release of their information must sign and date this form.

Section 2 of the CF 887 must be completed and signed by the participant's medical provider, mental health provider, or another qualified professional familiar with the participant's condition. Should a participant need help completing Section 2 of the CF 887, the CWD must assist them with collecting the required information. This may include providing the CF 887 with Section 1 complete to the participant's health care provider for completion of Section 2.

Pursuant to [ACL No. 22-20](#), if an electronic signature is used, the CWD must provide the participant with a printed copy of the completed form with instructions on how to correct any errors or omissions, so the participant can review the information and make any required changes within ten days after the electronic signature is complete.

The CF 887 is an optional form for counties to use to verify information. If a county chooses to use this form, the CF 887 must be used as provided, with no substitutions or alterations permitted. This form will not be available in the California Statewide Automated Welfare System (CalSAWS) and can only be downloaded from the California Department of Social Services (CDSS) website.

CalFresh Able-Bodied Adults Without Dependents Volunteer Work Hours Verification Form (CF 888)

The CF 888 is a new optional form developed to verify volunteer work hours for non-exempt ABAWDs. ABAWDs may engage in community service or volunteer work to satisfy the ABAWD work requirement. ABAWD work hours are a mandatory requirement and must be verified.

Section 1 of the CF 888 must be completed by the CalFresh participant. This section collects CalFresh participant information and specifies form submission instructions.

Section 2 of the CF 888 must be completed and signed by a representative of the organization where the ABAWD volunteers or performs community service.

Pursuant to [ACL No. 22-20](#), if an electronic signature is used, the CWD must provide the participant with a printed copy of the completed form with instructions on how to correct any errors or omissions, so the participant can review the information and make any required changes within ten days after the electronic signature is complete.

The CF 888 is an optional form for counties to use to verify volunteer work hours. If a county chooses to use this form, the CF 888 must be used as provided, with no substitutions or alterations permitted. This form will not be available in CalSAWS and can only be downloaded from the CDSS website.

Copies and Translations

Forms referenced in this letter are available on the [CDSS Forms/Brochures webpage](#). When CDSS completes translations of a form, 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 the Translation Services Section at its@dss.ca.gov. 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. See [All County Letter \(ACL\) 22-56](#).

Per [MPP Section 21-115](#), the County Welfare Departments (CWDs) must ensure 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 read and interpret the form if an applicant or recipient requests it. See [ACL 22-56](#).

Additionally, the CWDs must provide auxiliary aids and services to persons with vision, hearing, or speech disabilities, where applicable. More information regarding provisions for services to applicants and recipients who have limited English proficiency or who have disabilities can be found in [MPP Section 21-115](#) and [ACL 19-45](#).

If you have any questions or need additional guidance regarding the information in this letter, please contact the CalFresh Policy Bureau at CalFreshPolicy@dss.ca.gov.

Sincerely,

Original Document Signed By

ALEXIS FERNÁNDEZ GARCIA
Deputy Director
Family Engagement and Empowerment Division

Attachments

CALFRESH MEDICAL CERTIFICATION FORM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RELEASE OF INFORMATION

Purpose (Reason for Disclosure): CalFresh rules require some CalFresh participants to work to keep their CalFresh benefits. If you have a medical or mental health condition that keeps you from working, then you may be able to get CalFresh without having to satisfy the work requirement. The purpose of this form is to authorize the release of your health information to help us decide if you are excused from the CalFresh work rules. You can turn in this form online by uploading it to your BenefitsCal account at www.BenefitsCal.com, by mail, or in person at your local county office.

SECTION 1. PARTICIPANT INFORMATION AND AUTHORIZATION

Instructions: Section 1 must be completed by the CalFresh household member whose personal health information is being requested. Please complete all the information on this HIPAA release of information form. If any sections are left blank, then this form will be invalid, and it will not be possible for your health information to be shared as requested.

I give permission to _____ to release the
Name of Provider, Hospital, Clinic, Medical Group, or Organization

information listed in Section 2 of this form to _____ from my medical records on the conditions
Name of County

checked below:

☐ Physical Condition

☐ Mental Condition

☐ Disability

☐ Other (Describe): _____

Read and sign so that we can get information about your medical or mental health condition from your provider. By signing below, I understand that:

- This authorization is valid for one (1) year from the date of signature.
- I may revoke this authorization at any time. If my information has already been shared, it may be too late to stop the release of health information provided to the County Welfare Department.
- This information is needed by the County Welfare Department to determine eligibility for CalFresh.
- The County Welfare Department may not be subject to the same privacy laws as other healthcare providers. However, this information will be kept in the case file, and it will not be disclosed without my signed consent, unless the disclosure is specifically required by law.
- I have read this form or had this form read to me after it was completed.
- I can get a copy of this form if I ask for it.

Name (Printed)	Signature of CalFresh Household Member	Date Signed

SECTION 2. STATEMENT OF PROVIDER

Instructions: Section 2 must be completed and signed by the medical or mental health provider of the person named above. This form is used to help the county determine eligibility for CalFresh food benefits. If any sections are left blank, then this form will be invalid.

Please check the box that applies to your profession.

- ☐ I am a licensed or certified healthcare professional to diagnose or treat medical problems. This includes but is not limited to: Audiologist; Dentist; Drug or Alcohol Abuse Counselor; Mental Health Counselor; Midwife; Nurse Practitioner; Occupational Therapist; Optometrist; Orthodontist; Osteopath; Physical Therapist; Physician's Assistant; Podiatrist; or Social Worker.
- ☐ I am another type of healthcare professional (*Describe*): _____

Please answer the following questions for the person named above, where applicable.

- ☐ The person named above currently participates in a substance abuse treatment or other rehabilitation program.

Name of Program: _____

Start Date: _____

Expected End Date (*If known*): _____

- ☐ The person named above has a physical or mental health condition, illness, or disability that prevents them from working for at least 20 hours per week or 80 hours per month.
- ☐ The person named above has a disability that is expected to last at least 30 days and that prevents them from working at least 20 hours per week or 80 hours per month.

The medical condition is (*Check One*): ☐ Permanent ☐ Temporary

If known, this condition expected to end on (MM/DD/YY): _____

Printed Name of Provider (First, Middle, Last)	Phone Number
Title	
Address (Street, City, State, Zip Code)	
Signature of Provider	Date Signed

CALFRESH ABLE-BODIED ADULTS WITHOUT DEPENDENTS VOLUNTEER WORK HOURS VERIFICATION FORM

CalFresh rules require some CalFresh participants to work or participate in a qualifying work activity to keep their CalFresh benefits. Volunteering or doing community service is a qualifying work activity. This form may be used to verify volunteer or community service hours. You can turn in this form online by uploading it to your BenefitsCal account at www.BenefitsCal.com, by mail, or in person at your local county office.

SECTION 1. CALFRESH PARTICIPANT INFORMATION

This section must be completed by the CalFresh participant. Please fill in the information below.

Name of CalFresh Participant

Birthdate

Address

SECTION 2. VOLUNTEER ACTIVITY INFORMATION

This section must be completed by a representative of the organization where the person named above volunteers or does community service. Please fill in the information below.

Name of Organization

Name of Representative

Address

Telephone Number

For the month of _____, I certify that the person named above volunteered or performed community service for the organization I represent for _____ hours. The volunteer activity is:

☐ Ongoing

☐ One Time

Signature Of Representative	Date Signed
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