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

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

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

| | First Name | Last Name | CalFresh Case Number | CalFresh Status (active, pending, etc.) | Facility Entrance Date | Facility Exit Date | Date Notified County of Exit | Amount of Benefit Refund ($) |
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| 11 | | | | | | | | |
| 12 | | | | | | | | |

| | First Name | Last Name | CalFresh Case Number | CalFresh Status (active, pending, etc.) | Facility Entrance Date | Facility Exit Date | Date Notified County of Exit | Amount of Benefit Refund ($) |
|---|---|---|---|---|---|---|---|---|
| 13 | | | | | | | | |
| 14 | | | | | | | | |
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**I understand that per All County Letter No. 19-51, a portion of the CalFresh benefits must be returned to the client upon exiting the facility and that I will contact the county to assist in determining the amount to be returned. I understand that when a client leaves the facility, within 10 days, I must complete the CF 377.5B Change Report Form and I must return the Electronic Benefit Transfer (EBT) card associated with the client's case to the county. I understand that after a client leaves the facility, I am not entitled to spend their CalFresh benefits or use their EBT card. I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true, correct, and complete.**

______________________________
DAA Treatment Center or GLA Representative (Print)

______________________________
DAA Treatment Center or GLA Representative (Signature)

______________________________
Phone

______________________________
Date