

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, Sacramento, California 95814



July 28, 2000

ALL-COUNTY INFORMATION NOTICE I-77-00

TO: ALL COUNTY WELFARE DIRECTORS  
 ALL Cal-WORKS COORDINATORS  
 ALL FOOD STAMP COORDINATORS

**REASON FOR THIS TRANSMITTAL**

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

SUBJECT: REVISED CW 7 AND SAWS 7 FOR CHANGES IN FOOD STAMPS REGULATIONS

REFERENCE: CODE OF FEDERAL REGULATIONS SECTION 273.2.(f)(1)(iii) AND SECTION 273.2 (f) (3) (I)

This notice transmits copies of the revised versions of the following forms for the Food Stamp program.

Monthly Eligibility Report SAWS 7  
 Monthly Eligibility Report CW 7 (Originally released ACIN I-48-00)

The forms are revised to conform to the amended Food Stamp regulations for verifying shelter costs. Counties should begin using the revised forms as soon as the old stock is depleted.

The CW 7 and SAWS 7 transmitted with this ACIN are designated as "Required Form – Substitute Permitted." Welfare Departments must obtain prior approval from the California Department of Social Services (CDSS) before implementing a modification or substitution to these and other "Substitute Permitted" forms. For CalWORKs and Food Stamp program changes, the procedures for submission of a change request are outlined in Management and Office Procedures regulations 23-400.22 and the Food Stamp Handbook Regulations 63-1250.

After you receive a copy of an English form, or a Notice of Action (NOA) message, please allow six to eight weeks for the form or message to be translated and mailed to your CalWORKs Forms Coordinator. Language Translation Services (LTS) will mail camera-ready copies of Spanish, Chinese, Cambodian, Vietnamese and Russian translations as soon as they become available. You do not need to initially request forms or messages from LTS. To order additional camera-ready forms or messages in Spanish, Chinese, Cambodian, Vietnamese or Russian, fax your request to LTS at (916) 657-3429 or e-mail it to [LTS@dss.ca.gov](mailto:LTS@dss.ca.gov).

For a camera-ready copy and/or an additional copy of an English form, please call Forms Management Unit (FMU) (916) 657-1907. If your office has Internet access,

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you may obtain various forms (not including messages) from the CDSS web page at: <http://www/dss/ca/hwnet.gov>. FMU is currently in the process of making forms available on the Internet. If the name, mailing address or e-mail address of your CalWORKs forms Coordinator changes, please contact FMU by telephone at (916) 657-1907 or by e-mail to [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov).

State produced stock of the English and Spanish language versions for these forms will be available 30 to 60 days after the release of this letter. Stock of each form may be ordered from the CDSS Warehouse upon receipt of the Notice of Form Change (GEN 127), in accordance with the procedures in the County Forms Catalog.

### Translations

Your CalWORKs Forms Coordinator is to distribute forms and NOA messages to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English speaking populations as required by the Dymally Alatorre Bilingual Services Act (Government Code Section 7209 et seq) and by the state regulations in Manual of Policies and Procedures (MPP) Division 21, civil Rights Nondiscrimination Section 115. Among other things, this regulation section includes requirements for providing forms in the applicant's or recipient's primary language.

If you have any questions or need further information regarding the forms-related issues in this letter please contact Terry Mallin of the CalWORKs Eligibility Bureau at (916) 653-8395.

Sincerely,

**Original document signed by**  
**Pat Sutherland for**  
GARY SWANSON, Chief  
Food Stamp Branch

Enclosure

# MONTHLY ELIGIBILITY/STATUS REPORT



## For Cash Aid, Food Stamps and Medi-Cal/State-Run County Medical Services Program (CMSP)

THIS REPORT IS FOR THE MONTH OF \_\_\_\_\_

Complete, sign, and return this report by the 5th of the month.

- If you do not send in a complete report including, but not limited to, answering all questions in Part B below and attaching proof when we ask for it, your benefits may be delayed, changed, or stopped. Attach a separate sheet of paper if needed.
- You must report **within 5 days** any change that may affect your eligibility for or the amount of your cash aid or **within 10 days** of any change that may affect your eligibility or share of cost for Medi-Cal/State CMSP.  
**Important:** If you don't want cash aid, food stamps and/or Medi-Cal/State CMSP anymore, fill in PART A below, sign and date Item 9.
- Facts you report may result in your benefits going up, down, or being stopped.

Need Help? Call your worker.

Worker: \_\_\_\_\_

Phone: \_\_\_\_\_

**PART A Request to Stop Benefits** (If you fill in this part, sign and date Item 9 on the back of this form. You can reapply at any time.)  
I ask that my  Cash Aid  Food Stamps  Medi-Cal  State CMSP be stopped on the last day of: \_\_\_\_\_ MONTH/YEAR

**PART B** If you get food stamps, answer for everyone in your household. If you do not get food stamps, answer for everyone on cash aid and/or Medi-Cal/State CMSP, including children, parents, stepparents, your spouse, and anyone temporarily absent from the home.

**1 Did anyone get money from a job or training program?**  YES  NO

- If "YES", complete below. Include tips, vacation pay or income in kind, such as earned housing. List gross amounts before deductions for each week in the month. **Attach paystubs or other proof of earnings.**
- **If self-employed: For Food Stamps and Medi-Cal/State CMSP:** List business costs on a separate sheet of paper and **attach proof** of income and costs. **For Cash Aid: Attach proof of income. If claiming actual expenses,** list business expenses on a separate sheet of paper and **attach proof of costs.**

WHO GOT INCOME	EMPLOYER'S NAME (✓)  <input type="checkbox"/> JOB <input type="checkbox"/> TRAINING	GROSS AMOUNT	\$	\$	\$	\$	\$
		ACTUAL DATE RECEIVED					
		NO. of HOURS WORKED					
WHO GOT INCOME	EMPLOYER'S NAME (✓)  <input type="checkbox"/> JOB <input type="checkbox"/> TRAINING	GROSS AMOUNT	\$	\$	\$	\$	\$
		ACTUAL DATE RECEIVED					
		NO. of HOURS WORKED					

**2 If anyone above paid for care of a child, disabled person or other dependent while working, seeking work, or in training, list here and attach proof of payment.**

Name Of Person Who Received Care	Cost	Name Of Person Who Received Care	Cost
	\$		\$

**3 Did anyone receive money or benefits from any other source?**  YES  NO  
Include: Child/spousal support; interest or dividends; gambling/lottery winnings; insurance or legal settlements; strike benefits; cash, gifts, loans, scholarships; tax refunds; any government benefits, like Social Security, Supplemental Security Income/ State Supplementary Payment (SSI/SSP), unemployment, workers compensation, state disability indemnity, veterans or railroad retirement, other private or government disability or retirement; rental income and rental assistance; free housing/utilities/clothing/food; or anything else. If "YES", complete below. **Attach proof.**

WHO GOT INCOME	SOURCE OF INCOME	GROSS AMOUNT	\$	\$	\$	\$	\$
		DATE RECEIVED					
WHO GOT INCOME	SOURCE OF INCOME	GROSS AMOUNT	\$	\$	\$	\$	\$
		DATE RECEIVED					

**4 If anyone who gets food stamps or Medi-Cal/State CMSP and paid court ordered child support this month, list the amount they paid. Report any changes in the court order. Attach proof. \$**

**5 Is any member in the cash aid or food stamp household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? If "YES", who:**  YES  NO

COUNTY USE ONLY

E.W. INITIALS

DATE:

**6** Has any member of the cash aid and/or food stamp household been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s)? Give facts for crimes committed after August 22, 1996. If "YES", complete below:  YES  NO

FULL NAME OF PERSON(S)	RELATIONSHIP TO YOU	DATE DRUG CRIME COMMITTED	DATE OF FELONY CONVICTION	CONVICTION WAS FOR (✓) <input type="checkbox"/> POSSESSION <input type="checkbox"/> DISTRIBUTION <input type="checkbox"/> USE <input type="checkbox"/> OTHER: (EXPLAIN)
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**7** Did anyone move into or out of your home, or did you move in with someone else? Include: newborns; temporary absences; anyone who died, entered or left a hospital, etc. If "YES", complete below:  YES  NO

FULL NAME OF PERSON(S)	RELATIONSHIP TO YOU	EXPLAIN WHAT CHANGED	DATE OF CHANGE
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**8** Does anyone have anything else to report? Include expected changes. Attach proof, including any costs. If "YES", complete below:  YES  NO

- **Income:** Starts, changes or stops.
- **Job/ Training:** Start, stop, quit, refuse a job or training, a change in number of hours, or go out on strike.
- **School-Ages 6 through 17:** For Cash Aid Only: Stop or start attending school regularly.
- **School-Age 16 or older:** Start or stop school or college. Costs for tuition, school transportation, etc.
- **Property:** Buy, sell, trade, give away, or get a motor vehicle, home, land, or trusts, etc. (personal or business).
- **Checking/ Savings:** Open/close a checking or savings account(s) or the balance is different at the end of the month.
- **Babies:** Become pregnant, have a baby, abort or miscarry.
- **Citizenship/ Immigration Status:** A citizenship or immigration status changes or anyone gets a new card, form or letter from the INS.
- **Marital:** Marry, divorce, or separate.
- **Disability:** Become disabled or recover from a disability/major illness.
- **Medical Costs:** For Food Stamps Only: Anyone who is disabled or age 60 or older may report new medical costs not being used to figure your current allotment. For Medi-Cal/State CMSP Only: Medical costs that were due to an injury or accident caused by someone else.
- **Insurance:** Start, stop, or change life, dental or health insurance benefits including MEDICARE coverage.
- **IHSS:** Starts or stops getting In-Home Supportive Services.

NAME OF PERSON(S)	RELATIONSHIP TO YOU	EXPLAIN WHAT HAPPENED	DATE OF CHANGE
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**ADDRESS CHANGE** Fill in this section ONLY if you have moved or have a new mailing address.

NEW HOME ADDRESS (NUMBER, STREET NAME, AVENUE, BLVD., ETC.) APT. NO.	CITY	STATE	ZIP CODE	NEW PHONE NUMBER ( )
DATE MOVED	NEW MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)	CITY	STATE	ZIP CODE

If you are getting Food Stamps, you may be asked to provide proof of your new shelter costs. Are you paying rent at the address you have listed?  YES  NO  
 If YES, amount of rent \$\_\_\_\_\_. Paying utilities?  YES  NO If YES, amount of utilities \$\_\_\_\_\_.

**CERTIFICATION**

**I UNDERSTAND THAT:** If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. And I may be charged with committing a felony if more than \$400 in cash aid, food stamps, and/or Medi-Cal/State CMSP is wrongly paid out AND I may be given:

- PENALTIES FOR CASH AID WELFARE FRAUD:** If on purpose I do not follow cash aid rules, my cash aid can be lowered for a period of time and I may be fined up to \$10,000 and/or sent to jail or prison for up to 3 years. My cash aid can be stopped:
- For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third.
  - For submitting one or more applications to get aid in more than one case for the same time period: 2 years for the first conviction, 4 years for the second, or forever for the third.
  - For conviction of felony fraud to get aid: 2 years for theft of amounts under \$2,000; 5 years for amounts of \$2,000 through \$4,999.99; and forever for amounts of \$5,000 or more.
  - Forever: for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county wrong facts for an ineligible child or a child that does not exist; getting more than \$10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing.
- PENALTIES FOR FOOD STAMP FRAUD:** If on purpose I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:**
- I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
  - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second.
  - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever.
  - I gave the county false identity or residence information, so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.

**YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE.**

**9** 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 and correct and complete for the entire report month.

**WHO MUST SIGN BELOW:** For Cash Aid: you, your aided spouse and the other parent (of cash aided children) if living in the home.  
 For Food Stamps: the head of household, household member or the household's authorized representative.  
 For Medi-Cal/State CMSP: you, your spouse, or the person acting for the beneficiary.

SIGNATURE OR MARK	DATE SIGNED	HOME PHONE ( )	CONTACT PHONE ( )
SIGNATURE OF SPOUSE OR OTHER PARENT OF CASH AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR OTHER PERSON COMPLETING FORM	DATE SIGNED

# MONTHLY ELIGIBILITY REPORT

## For Cash Aid and Food Stamps



THIS REPORT IS FOR THE MONTH OF \_\_\_\_\_

- Complete, sign, and return this report by the 5th of the month.
- If you do not send in a complete report including, but not limited to, answering all questions and attaching proof when we ask for it, your benefits may be delayed, changed, or stopped. Attach a separate sheet of paper if needed.
- You must report **within 5 days** any change that may affect your eligibility for or the amount of your cash aid.
- If you get food stamps, answer for everyone in your household. If you do not get food stamps, answer for everyone on cash aid, including children, parents, stepparents, your spouse, and anyone temporarily absent from the home.
- Facts you report may result in your benefits going up, down, or being stopped.

Need Help? Call your worker.

Worker: \_\_\_\_\_

Phone: \_\_\_\_\_

① **Did anyone get money from a job or training program?**  YES  NO

- If "YES", complete below. Include tips, vacation pay or income in kind, such as earned housing. List gross amounts before deductions for each week in the month. **Attach paystubs or other proof of earnings.**
- **If self-employed: For Food Stamps:** List business costs on a separate sheet of paper and attach proof of income and costs.  
**For Cash Aid:** **Attach proof** of income. If you claim actual expenses, list business expenses on a separate sheet of paper and **attach proof** of expenses.

Who Got Income	Employer's Name (✓)  <input type="checkbox"/> Job <input type="checkbox"/> Training	Gross Amount	\$	\$	\$	\$	\$	
		Actual Date Received						
		No. of Hours Worked						
Who Got Income	Employer's Name (✓)  <input type="checkbox"/> Job <input type="checkbox"/> Training	Gross Amount	\$	\$	\$	\$	\$	
		Actual Date Received						
		No. of Hours Worked						

② **If anyone above paid for care of a child, disabled person or other dependent while working, seeking work, or in training, list here and attach proof of payment.**

Name of Person Who Received Care	Cost	Name of Person Who Received Care	Cost
	\$		\$

③ **Did anyone receive money or benefits from any other source?**  YES  NO

Include: Child/spousal support; interest or dividends; gambling/lottery winnings; insurance or legal settlements; strike benefits; cash, gifts, loans, scholarships; tax refunds; any government benefits, like Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), unemployment, workers compensation, state disability indemnity, veterans or railroad retirement, other private or government disability or retirement; rental income and rental assistance; free housing/utilities/clothing/food; or anything else. If "YES", complete below. **Attach proof.**

Who Got Income	Source of Income	Gross Amount	\$	\$	\$	\$	\$
		Date Received					
Who Got Income	Source of Income	Gross Amount	\$	\$	\$	\$	\$
		Date Received					

④ **If anyone gets food stamps and paid court ordered child support this month, list the amount they paid. Report any changes in the court order. Attach proof. \$**

⑤ **Is any member in the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? If "YES", who:**  YES  NO

COUNTY USE ONLY

E.W. INITIALS

DATE:

**6** Has any member of the household been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s)? Give facts for crimes committed after August 22, 1996.  YES  NO  
If "YES", complete below:

FULL NAME OF PERSON(S)	RELATIONSHIP TO YOU	DATE DRUG CRIME COMMITTED	DATE OF FELONY CONVICTION	CONVICTION WAS FOR (✓) <input type="checkbox"/> POSSESSION <input type="checkbox"/> DISTRIBUTION <input type="checkbox"/> USE <input type="checkbox"/> OTHER: (EXPLAIN)
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**7** Did anyone move into or out of your home, or did you move in with someone else? Include: newborns; temporary absences; anyone who died, entered or left a hospital, etc. If "YES", complete below:  YES  NO

FULL NAME OF PERSON(S)	RELATIONSHIP TO YOU	EXPLAIN WHAT CHANGED	DATE OF CHANGE
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**8** Does anyone have anything else to report? Include expected changes. Attach proof, including any costs.  YES  NO  
If "YES", complete below:

<ul style="list-style-type: none"> <li><b>Income:</b> Starts, changes or stops.</li> <li><b>Job/ Training:</b> Start, stop, quit, refuse a job or training, a change in number of hours or go out on strike.</li> <li><b>School-Ages 6 through 17:</b> For Cash Aid Only: Stop or start attending school regularly.</li> <li><b>School Age 16 or Older:</b> Start or stop school or college. Costs for tuition, school transportation, etc.</li> <li><b>Property:</b> Buy, sell, trade, give away, or get a motor vehicle, home, land, or trusts, etc. (personal or business)</li> <li><b>Checking/ Savings:</b> Open/close a checking or savings account(s) or the balance is different at the end of the month.</li> <li><b>Babies:</b> Become pregnant, have a baby, abort or miscarry.</li> </ul>	<ul style="list-style-type: none"> <li><b>Citizenship/ Immigration Status:</b> A citizenship or immigration status changes or anyone gets a new card, form or letter from the INS.</li> <li><b>Marital:</b> Marry, divorce, or separate.</li> <li><b>Disability:</b> Become disabled or recover from a disability/major illness.</li> <li><b>Medical Costs:</b> For Food Stamps Only: Anyone who is disabled or age 60 or older may report new medical costs not being used to figure your current allotment.</li> <li><b>Insurance:</b> Start, stop, or change life, dental or health insurance benefits including MEDICARE coverage.</li> <li><b>IHSS:</b> Starts or stops In-Home Supportive Services.</li> </ul>
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NAME OF PERSON(S)	RELATIONSHIP TO YOU	EXPLAIN WHAT HAPPENED	DATE OF CHANGE
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**ADDRESS CHANGE** Fill in this section ONLY if you have moved or have a new mailing address.

NEW HOME ADDRESS (NUMBER, STREET NAME, AVENUE, BLVD., ETC.) APT. NO. CITY	STATE	ZIP CODE	NEW PHONE NUMBER
DATE MOVED	NEW MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)	CITY	STATE ZIP CODE

If you are getting Food Stamps, you may be asked to provide proof of your new shelter costs. Are you paying rent at the address you have listed?  YES  NO  
If YES, amount of rent \$ \_\_\_\_\_. Paying utilities?  YES  NO If YES, amount of utilities \$ \_\_\_\_\_.

**CERTIFICATION**

**I UNDERSTAND THAT:** If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. And I may be charged with committing a felony if more than \$400 in cash aid, food stamps, and/or Medi-Cal/State CMSP is wrongly paid out **AND** I may be given:

**PENALTIES FOR CASH AID WELFARE FRAUD:** If on purpose I do not follow cash aid rules, my cash aid can be lowered for a period of time and I may be fined up to \$10,000 and/or sent to jail or prison for up to 3 years. My cash aid can be stopped:

- For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third.
- For submitting one or more applications to get aid in more than one case for the same time period: 2 years for the first conviction, 4 years for the second, or forever for the third.
- For conviction of felony fraud to get aid: 2 years for theft of amounts under \$2,000; 5 years for amounts of \$2,000 through \$4,999.99; and forever for amounts of \$5,000 or more.
- Forever: for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county wrong facts for an ineligible child or a child that does not exist; getting more than \$10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing.

**PENALTIES FOR FOOD STAMP FRAUD:** If on purpose I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.

\* If I am found guilty in any court of law because:

- I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
- I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second.
- I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever.
- I gave the county false identity or residence information, so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.

**YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE.**

**9** 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 and correct and complete for the entire report month.

**WHO MUST SIGN BELOW:** For Cash Aid: you, your aided spouse and the other parent (of cash aided children) if living in the home.  
For Food Stamps: the head of household, a household member or the household's authorized representative.

SIGNATURE OR MARK	DATE SIGNED	HOME PHONE	CONTACT PHONE
SIGNATURE OF SPOUSE OR OTHER PARENT OF CASH AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR OTHER PERSON COMPLETING FORM	DATE SIGNED