

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, Sacramento, CA 95814



July 21, 1997

ALL COUNTY INFORMATION NOTICE I- 43-97

TO: ALL COUNTY WELFARE DIRECTORS

**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: CHANGES TO CA 8, STATEMENT OF FACTS FOR ADDITIONAL PERSON, THE SUPPLEMENTAL APPLICATION FOR FOOD STAMPS AND REQUEST FOR CASH AID**

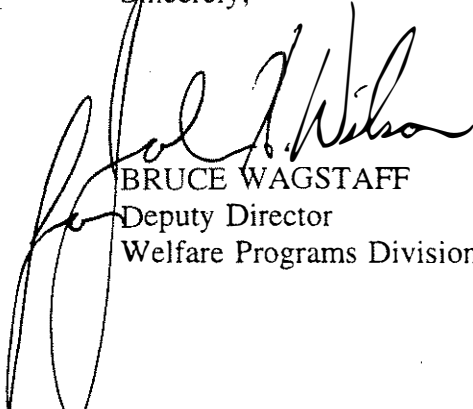
This letter transmits the revised CA 8 (5/97), Statement of Facts for Additional Person, (Supplemental Application for Food Stamps and Request for Cash Aid). The form is updated to parallel the JA 2, Statement of Facts for Cash Aid and Food Stamps (4/97). It replaces the BC CA 8 (11/92), Statement of Facts for Additional Persons, which is being obsoleted. Information gathered by the CA 8 for citizen/non-citizenship status eliminates the need to complete the CA 64, Statement of Citizenship/Alien Status. Further details may be found in Attachment A and B.

Attachment A contains information regarding instructions, implementation, stock, obtaining camera-ready copies and translations. Attachment B provides a detailed outline of the changes to the form.

If you have questions or need further information, please contact the following staff regarding the specific program areas:

- The CA 8 or this letter: Donna Morgan at (916) 654-5709 or CALNET 464-5709;
- Food Stamp Program: Melissa Buchanan at (916) 654-8467 or CALNET 464-8467;
- Asian/Spanish translations: Shirley LuKung at (916) 654-1277 or CALNET 464-1277.

Sincerely,



BRUCE WAGSTAFF  
Deputy Director  
Welfare Programs Division

Attachments

c: CWDA

## **Attachment A**

### **INSTRUCTIONS and IMPLEMENTATION**

The CA 8 (5/97) replaces the BC CA 8, Statement of Facts for Additional Persons (11/92) which is being obsoleted. A separate form must be filled out for each additional person. The CA 8 does not provide for inclusion of detailed work history information or principal earner determination; therefore, we suggest that the JA 2/SAWS 2 be used for that determination. Information provided on the CA 8 for citizen/non-citizenship status eliminates the requirement to complete the CA 64, Statement of Citizenship/Alien Status. For Food Stamps purposes, counties should continue to use TEMP 2131, Addendum to Food Stamp Application, to obtain information about non-citizens. It is recommended that counties begin using the revised CA 8 as soon as administratively feasible.

### **STOCK**

The CA 8 is designated as a recommended form. The CA 8 may be ordered from the California Department of Social Services (CDSS) warehouse according to the forms ordering procedures in the County Forms Catalog. Counties may order upon receipt of the Notice of Change Form (Gen 127) which is issued when stock is available. The English and Spanish versions of the BC CA 8 will be destroyed when the CA 8 (5/97) stock becomes available.

### **CAMERA-READY COPIES AND TRANSLATIONS**

Counties needing a camera-ready copy of the CA 8 in English and Spanish may call the Forms Management Unit at (916) 657-1907 or CALNET 437-1907. Camera-ready copies of the Asian language (Chinese, Cambodian and Vietnamese) versions, will be mailed to the county contact person as soon as they have been translated. If counties do not receive the translation, they may call the Language Services Bureau at (916) 464-1282 or CALNET 464-1282. To order more than one form, counties may FAX their requests to (916) 657-3429 or CALNET 473-3429.

## Attachment B

### CHANGES TO THE STATEMENT OF FACTS FOR ADDITIONAL PERSON, CA 8

#### OVERVIEW:

Many of the changes made on the CA 8 parallel changes made to the most current JA 2, Statement of Facts for Cash Aid and Food Stamps (4/97). The narrative is revised and questions and subset items are reformatted. New questions are added that were not previously addressed on the form but are included to parallel the JA 2. The narrative and format for previous questions that included more than one person have been changed to one-person only. The differences between the CA 8 (5/97) and the BC CA 8, Statement of Facts for Additional Persons (11/92) are outlined below. "PAGE" numbers below refer to placement on the CA 8 and "Old Item" number refers to its placement on the BC CA 8. The changes and additions to the form also necessitated various changes in the County Use Only (CUO) section and may not be detailed in the following list of changes.

#### PAGE 1

Item 2/Old Item 2: The following subset items in the identifying information for new person in the home are added, revised and/or reformatted:

- The check box for Citizenship/Immigration Status is retitled "Citizen/Non-citizen Status." A check box is added for "Asylee." The verification required in the CUO section is expanded to include "Citizen," "Eligible Non-citizen," "Sponsored," "SAVE," and "Date of Entry to U.S."
- Narrative and check box are added to indicate if pregnant.
- Narrative and check box are added to indicate if he/she is a parent. The proximity of the check boxes for "Birthdate," "Pregnant" and "Is he/she a Parent?" permits capture of the information needed if a referral to Cal-Learn or GAIN is necessary. Verification of Cal-Learn and GAIN (Greater Avenues for Independence) referral is added in the CUO section. These changes allowed elimination of old item 5.
- A check box for "School Status" is added and replaces old item 6.
- The narrative "Is he/she related to anyone in the home?" is changed to "Related to applicant/caretaker relative/head of household?"
- A subset item is added to indicate if any other names are used.
- Narrative and check box are added to provide marital status.
- The "Blind or Disabled" check box narrative is expanded to "Blind, Deaf or Disabled."
- The CUO section of Item 2 is substantially revised and reformatted.

Item 3/Old Item 3: The narrative is revised to add "homeless assistance" to the examples of possible benefits received. The subset box is revised changing "Date Applied" to "When" and deleting "Date Last Received."

Item 4/Old Item 19: This item regarding child's need for aid is reformatted and boxes are added to indicate if mother and father live in home and, if not, the reason other parent does not live in the home.

Item 5/Old Item 4 is revised, reformatted and a check box for "Honorable Discharge" is added.

Item 6 and 7/Old Item 20 and 21: The narrative and format are revised regarding relocation to California from another state.

## **PAGE 2**

Items 8 A & B are added regarding foster child.

Items 9 A & B/Old Item 7: These items are expanded regarding the additional person's school/training.

Item 10 is added regarding sanctions, welfare fraud and intentional program violations (IPVs).

Item 11 is added regarding a hiding or running felon, or parole or probation violator.

Item 12, 13 and 14/Old Item 16, 17 and 18: The format is revised regarding Food Stamp household eligibility.

Item 15/Old Item 15 is expanded naming various food distribution programs.

## **PAGE 3**

Item 16/Old Item 12 regarding employment is expanded to include expectations of future employment.

Item 17A/Old Item 14: The subset of this item regarding care of a child or disabled adult is revised and reformatted.

Item 17B is added regarding child care costs paid by someone else.

Item 18/Old Item 23: The narrative is revised changing 30 days to 60 days for job quit/training refusal. The subset format is also revised.

Item 19/Old Item 8: The narrative and format regarding a striker are revised.

Item 20 is added regarding child/spousal support.

Item 21/Old Item 13: The narrative and format regarding other benefits in the last 12 months are revised.

## **PAGE 4**

Item 22/Old Item 9: Narrative is added to include buying real estate outside the U.S. The item is also reformatted. The CUO section is substantially revised.

Item 23 A/Old Item 10: The narrative is revised to include IRAs and Retirement Funds along with Stocks, Bonds and Certificates. The format is revised.

Item 23 B regarding income from resources is added.

Item 24/Old Item 11: The narrative of the question is revised to include "leasing" a motor vehicle, change camper to mobile home and add off-road vehicles (ATVs), seadoos, and jetskis. The subset adds a check box to indicate if vehicle is leased and a check box to indicate if licensed. "Estimated Value" replaces "Amount of Last License Fee." A check box is added in the CUO section for "Exempt" and "Leased."

Item 25/Old Item 24: The narrative and format in the subset are revised.

Item 26/Old Item 25: The narrative is revised regarding the sale or transfer of real or personal property noting the time period of two years for cash aid and three months for food stamps. The subset is deleted.

Item 27/Old Item 26: The subset is reformatted.

Item 28/Old Item 27: The narrative is revised to correct "Champus" to all caps "CHAMPUS." The subset is expanded to request more information. This permits the documentation of the Medicare premium eligible for a Food Stamp deduction.

## **PAGE 5**

Item 29 is added regarding medical expenses for the current month or the three months prior to the month of completion.

Item 30 regarding health insurance available but not applied for is added.

Item 31 regarding special needs due to disability caused by injury or accident is added.

Item 32 A & B are added regarding special medical conditions requiring special diet, transportation, etc., and In-Home Supportive Services (IHSS). The item identifies potential eligibility for cash aid to the higher MAP amount and for Food Stamps a medical deduction for out-of-pocket IHSS expenses.

Item 33 A-D/Old Item 28 A-C: These items are expanded to include other available services such as Women, Infants and Children (WIC) Special Supplemental Food Program. The CUO section is also substantially revised and reformatted.

**PAGE 6**

**CERTIFICATION SECTION**

This section is changed to a two-column format and expanded to include more details. Cash aid penalties and food stamp penalties are stated separately. The penalties for not following cash aid rules have been updated.

A section is added at the end for the EW's signature and date.

**STATEMENT OF FACTS FOR ADDITIONAL PERSON**

(Supplemental Application for Food Stamps and Request for Cash Aid)

**INSTRUCTIONS:** Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "FS" for food stamps listed to the left side of each question tell you which questions are for which program.

**If you get cash aid,** and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

**For Food Stamp households,** which do not get cash aid or do not want cash aid for the new person, this form may be completed by a household member, an authorized representative or the new person.

**PLEASE PRINT IN INK**

**COUNTY USE ONLY**

CASE NAME \_\_\_\_\_  
 CASE NUMBER \_\_\_\_\_  
 WORKER NAME \_\_\_\_\_  
 WORKER NUMBER \_\_\_\_\_  
 DATE RECEIVED \_\_\_\_\_

CA ① Name of Person Completing Form (First, Middle, Last)  
 FS

CA ② List new person in the home, including a newborn.  
 FS

NAME (First Middle Last)		CITIZEN/NON-CITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Lawful non-citizen <input type="checkbox"/> Undocumented non-citizen <input type="checkbox"/> Sponsored <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other:	
SOCIAL SECURITY NUMBER	BIRTHDATE	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	IS HE/SHE A PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
BIRTHPLACE ( City/State/Country)	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	SCHOOL STATUS (✓) <input type="checkbox"/> Has a High School Diploma \$ <input type="checkbox"/> Has a GED <input type="checkbox"/> Currently Attending School! <input type="checkbox"/> Not Attending School (Explain):	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER NAME USED, BELOW: (Maiden, adoptive, etc.)	
RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO			

VERIFIED:	YES	NO
SSN		
FS ID		
Blind/Deaf/Disabled		
Residency		
DFA 285-C Comp.		
Referred to Cal-Learn		
CA 25 Completed		
CA 25 A Completed		
Referred to GAIN		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		
Date of Entry to U.S.		
Excluded HH Member Code		
Work/Training/GAIN Code		

CA ③ Has he/she applied for or received benefits in the past, such as: cash aid, food stamps homeless assistance, Medi-Cal, Refugee Cash Assistance? If "YES", explain:  YES  NO

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA ④ Is he/she a child under age 19? If "YES", complete below:  YES  NO

MOTHER'S NAME (✓) Lives in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	FATHER'S NAME (✓) Lives in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply) <input type="checkbox"/> Absence <input type="checkbox"/> Unemployment <input type="checkbox"/> Incapacity <input type="checkbox"/> Death
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VERIFIED: Deprivation  YES  NO

CA ⑤ Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? If "YES", explain:  YES  NO

LIST NAME, BRANCH OF SERVICE, ETC.	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO
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CA 5  YES  NO  
 Date Initiated \_\_\_\_\_

CA ⑥ Has he/she lived in California for the last 12 months in a row? If "YES", complete below:  YES  NO

LAST PLACE OF RESIDENCE (City, State)	DATE ARRIVED IN CALIFORNIA
---------------------------------------	----------------------------

Apply RFG:  YES  NO  
 State \_\_\_\_\_  
 RFG MAP \_\_\_\_\_  
 RFG Months \_\_\_\_\_

CA ⑦ Does he/she presently live in California and intend to continue living here? If "NO", explain:  YES  NO

CA (8) A. Is he/she a foster child(ren) living in the home?  YES  NO  
 FS

**COUNTY USE ONLY**

AFDC and FC Eligible/  
 CR Chooses:  
 Child:  AFDC  FC  
 CR:  AFDC  None

FS B. Do you want the foster child and their foster care income included in the Food Stamp case?  YES  NO

CA (9) A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below:  YES  NO  
 FS

VERIFIED:  
 School Enrollment  Yes  No  
 FS Eligible Student  Yes  No

NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):			

CA B. Complete below if he/she is enrolled in college or attending a similar educational institution.  
 FS

TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED	
TRANSPORTATION COST PER WEEK \$	AMOUNT PAID BY CARPOOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY \$	

CA (10) Has he/she had cash aid or food stamps stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation?  YES  NO  
 FS  
 If "YES", complete below:

WHY	WHEN	WHAT COUNTY/STATE
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CA (11) Is he/she hiding or running from the law for a felony, an attempted felony, or for a parole or probation violation?  YES  NO  
 FS

FS (12) Does he/she buy food and fix meals separately from others in the home?  YES  NO — Separate household eligible  Yes  No

FS (13) Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability?  YES  NO Separate household eligible  Yes  No

FS (14) Does he/she pay you for meals and/or a room?  YES  NO

CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY	Household Elects		
<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$			BOARDER	HH MEMBER	ROOMER

FS (15) Does he/she get food from any of the following programs?  YES  NO  
 • Communal dining facility for the elderly or disabled  
 • Food distribution program operated by a Native American reservation  
 • Other food program —  
 If "YES", complete below: —

NAME OF PROGRAM



CA FS **16** Is he/she working now or expecting to be working in the next two months? If "YES", complete below. Attach paystubs or other proof of earnings. (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).  YES  NO

EMPLOYER NAME	SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	OCCUPATION	DAYS/HOURS WORKED PER MONTH
PAY DATE(S)	WAGES BEFORE DEDUCTIONS \$ _____ per	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO	

**COUNTY USE ONLY**  
 if Exempt  
 CA  
 FS Adult  
 FS Child  
 FS S/E Farmer  Yes  No  
 Verification(s) on file:  Yes  No

CA FS **17** A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? If "YES", complete below:  YES  NO

NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID \$ _____	
NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID \$ _____	

**Child Care Informing Given to Client:**  
 Trustline Informing (CCP 2)  Yes  No  
 Health & Safety Certification (CCP 5)  Yes  No  
**Dependent Care Eligible**  
 CA  Yes  No FS  Yes  No

CA FS **B.** Does he/she get child care costs paid for them? Include costs paid by a relative or friend, Department of Education, Student Aid Block Grant, Cal-Learn, TCC, NET, GAIN, SCC, CAAP, etc. If "YES", complete below:  YES  NO

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$ _____
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$ _____

CA FS **18** Has he/she stopped or refused work or training in the last 60 days? If "YES", complete below:  YES  NO

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM	Did this person get or expect to get wages or benefits this month? If "YES", complete below. <input type="checkbox"/> YES <input type="checkbox"/> NO	
	LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFORE DEDUCTIONS \$ _____
	EXPECTED CHECK (DATE)	AMOUNT BEFORE DEDUCTIONS \$ _____
NUMBER OF HOURS OF WORK/TRAINING Last Month _____ This Month _____	LAST DAY OF WORK/TRAINING	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO
	REASON FOR LEAVING JOB/TRAINING	

**YES NO**  
 Emp. Statement  
 Good Cause Determ  
 Voluntary Quit  
 CA: 30 days  
 FS: 60 days

CA FS **19** Is he/she on strike? If "YES", complete below:  YES  NO

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM	NAME OF UNION	
	DATE WENT ON STRIKE	
	GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE \$ _____	

**Striker Regs Apply**  
 CA  Yes  No FS  Yes  No

CA FS **20** Does he/she pay child or spousal support? If "YES", complete below:  YES  NO

NAME OF CHILD OR SPOUSE	AMOUNT PER MONTH \$ _____	COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO	
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Court Order on File  Yes  No  
Amount Ordered \$ \_\_\_\_\_

CA FS **21** Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.? If "YES", complete below:  YES  NO

TYPE BENEFIT	AMOUNT	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly, Etc.)	DATE EXPECTED TO START AND STOP	(✓) if Exempt
		\$ _____				START: _____ STOP: _____	CA <input type="checkbox"/> FS <input type="checkbox"/>

CA (22) Does he/she own or is he/she buying any real estate, such as land and/or buildings anywhere, including outside the U.S.?  YES  NO  
 FS If "YES", complete below:

**COUNTY USE ONLY**

Home Exempt  Yes  No  
 Other Real Property  
 Market Value \$ \_\_\_\_\_  
 Amount Owed \$ \_\_\_\_\_  
 Net Value \$ \_\_\_\_\_  
 Lien Applicable  Yes  No

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	ESTIMATED VALUE	AMOUNT OWED
			\$	\$

CA (23) A. Does he/she have any of the following resources?  YES  NO  
 FS If "YES" check (✓) each item and explain below:

RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) if Exempt
				\$	AFDC FS
				\$	

CA B. Does he/she get income from any of these resources, such as interest, dividends, etc.?  YES  NO  
 FS If "YES" check (✓) each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA (24) Does he/she own, lease, or use any motor vehicles, such as a car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.?  YES  NO  
 FS If "YES", complete below:

(✓) if Exempt Leased  Exempt  Leased  
 Vehicle Valuation

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
<input type="checkbox"/> Leased				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

CA (25) Does he/she own or use personal property which cost at least \$100 for each item or is now worth at least \$100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings.  YES  NO  
 FS If "YES", complete below:

Owned Jointly  Owned Separately  
 Net Market Value \$ \_\_\_\_\_

OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED
			\$	\$
			\$	\$

CA (26) Has he/she sold, transferred or given away any real or personal property within the last 2 years for cash aid and within the last 3 months for food stamps?  YES  NO  
 FS If "YES", explain below:

Closed Bank Accounts:  Food Stamps in last 3 months

CA (27) Does he/she have any of the following insurance coverage: life, burial, disability or mortgage?  YES  NO  
 FS If "YES", complete below:

Total CSV (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 Total Countable Property: Items 22-27  
 AFDC \$ \_\_\_\_\_  
 FS \$ \_\_\_\_\_

NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID
			\$

CA (28) Does he/she have health or hospitalization insurance, including insurance paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.?  YES  NO  
 FS If "YES", complete below:

Health Care Options Explanation Given Referral \_\_\_\_\_  
 NA \_\_\_\_\_  
 DHS 6155  DFA 285-C  
 Medicare Gross Premium \$ \_\_\_\_\_

NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
		\$	

CA 29 Did he/she get medical/ pregnancy treatment this month or in the three months before this month?  YES  NO  
 If "YES", complete below:

COUNTY USE ONLY

Retro Medi-Cal Requested  Yes  No  
 Approved  Yes  No

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

CA 30 Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for?  YES  NO  
 If "YES", complete below:

DHS 6155

NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID
	\$	
	\$	

CA 31 Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs?  YES  NO  
 If "YES", complete below:

VERIFIED:  
 Higher/Lower MAP  Yes  No  
 Special Need  Yes  No  
 DFA 285-C

TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

CA 32 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item YES or NO:

CA Special Need  Yes  No  
 Amount \$ \_\_\_\_\_  
 VERIFIED:  
 CA  Yes  No  
 FS  Yes  No  
 DFA 285-C

	YES	NO		YES	NO
Special diet--prescribed by a doctor			Very high use of utilities		
Special transportation need			Special laundry service		
Special telephone or other equipment			Other (specify):		
Housework (no one in the home can do it)					

If "YES", explain:

CA 32 B. Does he/she get In-Home Supportive Services (IHSS)?  YES  NO  
 If "YES", who:  
 How much does he/she pay each month? \$ \_\_\_\_\_

DFA 285-C

CA 33 The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility. Check (✓) each item YES or NO.

CHDP Brochure and Explanation Given  
 Date: \_\_\_\_\_  
 Referral

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.

- Do you want more information about CHDP Services? .....
- Do you want CHDP medical services? .....
- Do you want CHDP dental services? .....
- Do you need help making appointments or with transportation to CHDP Services? .....

YES	NO

B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?

C. ,, Is anyone in the family breastfeeding a child? .....

Pregnant  
 Parent or Guardian of child under 5  
 Breastfeeding  
 Postpartum

If "YES", was the birth within the last 12 months? .....

If "YES" checked to 33 B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.

D. ,, Do you or any family member want free or low-cost family planning services? If "YES", call your health care plan or regular doctor.

WIC referral  
 Family Planning Information Given  
 Referred Date \_\_\_\_\_

Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.

# CERTIFICATION

I understand the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

**I understand that:**

- If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may also be fined up to \$5,000 and/or sent to jail/prison for 3 years.
- If I give false or incomplete facts, I may be fined or sent to jail or prison if I am found guilty of committing perjury.
- If I file more than one application for cash aid so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.
- If 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. And 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.

**I also understand that:**

- I must apply for and keep any available health coverage if no cost is involved; if I don't, my Medi-Cal will be denied or stopped.
- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, etc.
- A Social Security Number (SSN) is required by law and will be matched with other records to be sure that I am not getting aid in more than one case, or in another county or state.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution, may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get food stamps.

**I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.**

SIGNATURE (PARENT OR CARETAKER RELATIVE, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (OTHER PARENT IN THE HOME, IF APPLYING FOR CASH AID)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT	DATE
EW SIGNATURE	DATE