

NON-ASSISTANCE CALFRESH (NACF) HOUSEHOLD RECERTIFICATION FORM

This form can be used at recertification in lieu of the CalFresh only application for Non-Assistance CalFresh households who are subject to Quarterly Reporting/Prospective Budgeting.

Please fill out the following personal information for the person requesting CalFresh benefits.

Fill out as much of this form as you can, sign on page 5, and return it to your local CalFresh office. We need at least your name, address and signature. **If you are without money for food, you may be able to get emergency CalFresh benefits in three (3) days.**

You need to try to answer all questions on this recertification form.

NAME (FIRST, MIDDLE, LAST)			CONTACT PHONE: ()			COUNTY USE ONLY
HOME ADDRESS (NUMBER, STREET)			MAILING ADDRESS (IF DIFFERENT)			
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	

Are you homeless? YES NO

If "YES", are you temporarily staying in someone else's home? YES NO

If "YES", give date you began staying at this home: _____

EXPEDITED BENEFITS

1. Is someone in the household a Migrant/Seasonal Farmworker? YES NO

- a. How much is your rent or mortgage this month? \$ _____
- b. How much are your utilities this month, if separate from your rent or mortgage? \$ _____
- c. How much money do you have? This includes money in bank accounts, in your home, or any other place. \$ _____
- d. Do you have or will you receive any income this month? YES NO

List all your household income below:

NAME OF PERSON WHO GETS MONEY	HOW MUCH EACH MONTH?
	\$
	\$

Complete A, B & C below. If you don't complete this section, the county will do it for you. Check all that apply. **THIS WILL NOT AFFECT YOUR ELIGIBILITY.**

A. ETHNICITY

Are you Hispanic or Latino? YES NO

B. RACE/ETHNIC ORIGIN (Select one or more of the following:)

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

C. PRIMARY LANGUAGE

- English Spanish Lao Tagalog American Sign Cantonese
- Cambodian Vietnamese Russian Other (specify) _____

2. List all persons living with you, including yourself. Attach a separate sheet of paper if needed.

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:
			HEAD OF HOUSEHOLD

Check all that apply:

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you?

U.S. Citizen/National Noncitizen Legal Permanent Resident Sponsored: YES NO

Do you buy and prepare food with this person? YES NO

3. Does anyone live in any of the following type of facilities or take part in any food program including those listed below? (check all that apply) YES NO
- | | |
|---|--|
| <input type="checkbox"/> Homeless Shelter | <input type="checkbox"/> Reservation for Native American |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Penal Institution |
| <input type="checkbox"/> Drug/Alcohol Rehabilitation Center | <input type="checkbox"/> Shelter for Battered Women |
| <input type="checkbox"/> Food Distribution Program | <input type="checkbox"/> Psychiatric Hospital/Mental Institution |

If YES, complete the following:

NAME:	NAME OF CENTER/SHELTER/FOOD PROGRAM ETC.	DATE ENTERED	DATE EXPECTED TO LEAVE

4. Do you pay anyone or does anyone pay you for meals and/or a room? YES NO
If YES, complete the following:

NAME OF PERSON WHO PAYS FOR MEALS/ROOM	NAME OF PERSON WHO PROVIDES MEALS/ROOM	CHECK ONE: (✓)	HOW MUCH?	HOW OFTEN?	NUMBER OF MEALS PER DAY
		<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both			

5. Is anyone 16 years of age or older enrolled in school, college or a training program? YES NO
If YES, complete the following:

NAME OF PERSON	NAME OF SCHOOL	ATTENDANCE	NUMBER OF UNITS PER SEMESTER/QUARTER	WORKING
		<input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other		<input type="checkbox"/> YES <input type="checkbox"/> NO Number Of Hours:
		<input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other		<input type="checkbox"/> YES <input type="checkbox"/> NO Number Of Hours:

6. Is anyone in the home unable to buy or fix meals because they are blind, deaf or disabled? YES NO
If YES, complete the following:

NAME	EXPLAIN

7. Is anyone in the home pregnant? YES NO
If YES, complete the following:

NAME	EXPECTED DUE DATE

8. Do you or anyone living in the home have any housing costs? YES NO
If YES, complete the following:

HOUSING COST	TOTAL COST	HOW MUCH DO YOU PAY?	HOW MUCH IS PAID BY RENTAL ASSISTANCE PROGRAMS, SUCH AS HUD, SECTION 8, ETC?	IF SOMEONE ELSE PAYS, HOW MUCH?	HOW OFTEN BILLED?
Rent					
House (mortgage) payment					
Property Taxes (If not in house payment)					
Insurance (If not in house payment)					
Other (explain):					

9a. Does anyone have any utility costs? YES NO
 If YES, please check all boxes below that apply.

Gas		Garbage or trash	
Electricity		Sewer	
Other fuel (such as propane, butane, wood, coal, etc.)		Telephone/other means of communication, such as internet, etc.	
Water		Other (explain)	

9b. Do you use gas, electricity or other fuel for heating or cooling? YES NO
 If YES, please check below.

Utility	Used for Heating or Cooling?
Gas	<input type="checkbox"/> YES <input type="checkbox"/> NO
Electricity	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Fuel	<input type="checkbox"/> YES <input type="checkbox"/> NO

10. Does anyone, including children, have any of the resources listed below? YES NO
 If YES, explain below:

- Cash or checks
- Mortgages
- Employee deferred compensation
- IRA or Keogh Plans
- Retirement Funds
- Certificate Deposit
- Checking or Saving accounts
- Oil, mining or mineral rights
- Sales contracts
- Trust funds
- Stocks, Bonds
- Money Market accounts
- Credit Union accounts
- Other

TYPE OF RESOURCE	OWNER	CURRENT VALUE	AMOUNT OWED (IF ANY)	NAME & ADDRESS OF BANK	ACCOUNT NUMBER

11. Does anyone own or is anyone buying real estate anywhere (in or outside of the United States)? YES NO
 If YES, complete the following:

TYPE	ADDRESS OR LOCATION	USED AS: <input type="checkbox"/> HOME <input type="checkbox"/> RENTAL	OWNER:	ESTIMATED VALUE: AMOUNT OWED:
TYPE	ADDRESS OR LOCATION	USED AS: <input type="checkbox"/> HOME <input type="checkbox"/> RENTAL	OWNER:	ESTIMATED VALUE: AMOUNT OWED:

12a. Is any member of your household avoiding felony prosecution, custody or confinement after conviction? YES NO
 If YES, explain below:

NAME	EXPLAIN	NAME	EXPLAIN

12b. Has any member of your household been found to be in violation of probation/parole? YES NO
 If YES, explain below:

NAME	EXPLAIN	NAME	EXPLAIN

13a. Since August 22, 1996, have you or any member of your household been convicted of a drug-related felony that has not been expunged?

If No, go to question #15.

If Yes: _____
NAME DATE CONVICTED

13b. Was the conviction for any of the following:

- Transporting, importing into this state, selling, furnishing, administering, giving away, possessing for sale, purchasing for the purposes of sale, manufacturing, or processing precursors with the intent to manufacture a controlled substance or cultivating, harvesting, or processing marijuana? YES NO
- Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? YES NO

14. Have you or any member of your household:

- a) Completed a government recognized drug treatment program? YES NO
- b) Participated in a government recognized treatment program? YES NO
- c) Enrolled in a government recognized drug treatment program? YES NO
- d) Been placed on a waiting list for a government recognized drug treatment program? YES NO
- e) Ceased the use of controlled substances? (Must show proof to your worker) YES NO

If YES, please explain: _____

15. You can authorize someone to act on behalf of the head of household in case of illness or other circumstances.

If you would like to authorize someone, complete below:

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE NUMBER

16. Are you interested in information or a referral for medical coverage (*Medi-Cal or Healthy Families*)? YES NO

APPLICANT/RECIPIENT CERTIFICATION

I have completed the questions above and read all the information. I understand the new CalFresh rules and penalties apply to my application or reapplication for CalFresh. I understand the new rules and agree to comply with them.

The U.S. Department of Agriculture prohibits discrimination in all its programs and activities on the basis of race, color, sex, religion, national origin, age, disability or political beliefs. You may file a complaint if you think you have been discriminated against. If you disagree with the decision of the county, an appeal process is available to you.

The information on this application may be shared with federal, state and local agencies only for the purposes of certifying eligibility for the CalFresh Program. This process may include confirmation with the U.S. Citizenship and Immigration Services (USCIS, formerly INS) of the immigration status only of those persons seeking CalFresh benefits. Federal law says the USCIS cannot use the information for anything else except cases of fraud.

SIGNATURE

I certify under penalty of perjury under the laws of the United States of America and the State of California that the information I have provided on this application form is true, correct and complete.

<input checked="" type="checkbox"/> Signature (Adult household member or Authorized Representative)	Date
<input checked="" type="checkbox"/> Signature of Witness or Interpreter	Date
<input checked="" type="checkbox"/> Signature of Eligibility Worker	Date
<input checked="" type="checkbox"/>	Date