



CDSS

WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**

744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

April 8, 2013

ALL COUNTY LETTER NO. 13-26

TO: ALL COUNTY WELFARE DIRECTORS  
ALL CalWORKs PROGRAM SPECIALISTS  
ALL CALFRESH COORDINATORS  
ALL COUNTY REFUGEE COORDINATORS  
ALL CONSORTIA MANAGERS

SUBJECT: CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS  
(CalWORKs) AND CALFRESH PROGRAMS: NEW AND REVISED FORMS AND  
NOTICES OF ACTION (NOAs) FOR THE SEMI-ANNUAL REPORTING (SAR)  
SYSTEM

REFERENCE: Assembly Bill (AB) 6 (Chapter 501, Statutes of 2011), All County Letter (ACL)  
NO. 12-25, and ACL NO. 12-59.

ACL No. 12-25, dated May 17, 2012, issued new policy instructions to the County Welfare Departments (CWDs) for the implementation of SAR in CalWORKs and CalFresh. ACL No. 12-59, dated, October 29, 2012, issued the first set of new and revised forms and NOAs to be used in conjunction with the new SAR policies. The purpose of this ACL is to transmit the second set of SAR forms. Three of the revised forms (the SAWS 2, the CW 8 and the CW 8A) can all be used as soon as administratively possible, and must be used no later than upon implementation of SAR. CWDs should begin using the remaining new and revised forms attached to this ACL upon implementation of SAR in each county. Changes to required forms, other than adding the county name, logo and contact information must be approved by CDSS prior to making the change unless instructed otherwise.

The remaining SAR forms and NOAs will follow in a subsequent ACL.

REASON FOR THIS TRANSMITTAL

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

## **CAMERA READY COPIES AND TRANSLATIONS**

For camera-ready copies in English, contact the Forms Management Unit at [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov). If your office has internet access you may obtain these forms from the CDSS webpage at [http://www.dss.cahwnet.gov/cdssweb/FormsandPu\\_271.htm](http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm).

When all translations are completed per Manual of Policies and Procedures (MPP) Section 21-115.2, including Spanish forms, they are posted on an on-going basis on the CDSS webpage. Copies of the translated forms can be obtained at [http://www.dss.cahwnet.gov/cdssweb/FormsandPu\\_274.htm](http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm).

For questions on translated materials, please contact Language Services at (916) 651-8876. Until translations are 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.

CWDs shall ensure that 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 shall be provided free of charge to the applicant/recipient. In the event that CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it. More information regarding translations can be found in MPP Section 21-115.

This ACL and other CDSS Letters and Notices are available on the internet at: <http://www.dss.cahwnet.gov/lettersnotices/default.htm>

If you have any questions regarding this ACL, please contact your CalWORKs County Consultant at (916) 654-1322. For questions related to CalFresh Policy, please contact the CalFresh Policy Bureau at (916) 654-1896.

Sincerely,

***Original Document Signed By:***

TODD R. BLAND  
Deputy Director  
Welfare to Work Division

Attachments

## CalWORKs AND CALFRESH FORMS FOR SEMI-ANNUAL REPORTING (SAR)

Form #	Form Title, Description, Explanation of Changes, and Directions for Use
CW 8 (03/13)	<p><b><u>Statement of Facts for an Additional Person (Recommended Form)</u></b></p> <p>This form will replace the current version of the CW 8 as soon as administratively possible, and no later than upon implementation of SAR. This form is used to add an additional person to an existing CalWORKs or CalFresh case. This form was updated with technical changes, such as updating form names and replacing references to Food Stamps with CalFresh; question 4 was updated to refer to “parent or caretaker relative” rather than “mother and father;” question 7 regarding Foster Care was updated to ensure Foster Care children are presented with all of their health care options; question 10 was split up into two questions: one about fleeing felons and one about parole or probation violations; question 17 was updated to ask if the earned income is expected to continue and to give clients a place to enter the anticipated start date of a new job; and question 22 was updated to ask if the unearned income is expected to continue.</p>
CW 8A (04/13)	<p><b><u>Statement of Facts to Add a Child Under 16 (Recommended Form)</u></b></p> <p>This form will replace the current version of the CW 8A as soon as administratively possible, and no later than upon implementation of SAR. This form is used to add a child under age 16 to an existing CalWORKs or CalFresh case. This form was updated with technical changes, such as updating form names and replacing references to Food Stamps with CalFresh; question 2 was updated to refer to “parent or caretaker relative” rather than “mother and father;” question 3 was added regarding Foster Care to ensure Foster Care children are presented with all of their health care options; question 5 was updated to ask if any changes to the income are expected; question 11 was split up into two questions: one about fleeing felons and one about parole or probation violations; and questions 11, 12 and 13 were reworded to clarify that the child must have been charged as an adult for the felony crimes in question and have been found by a court of law to be in violation of their probation or parole.</p>
CW 25A (02/13)	<p><b><u>Payee Agreement for Minor Parent (Required Form, Substitutes Permitted)</u></b></p> <p>This form will replace the QR 25A upon implementation of SAR. This form is used for minor parent cases to designate the adult parent, legal guardian, or other adult relative as the payee in the minor parent’s CalWORKs case. This form was updated to change the reference from quarterly report forms to annual or semi-annual report forms, so this form can be used under both the SAR and Annual Reporting/Child Only (AR/CO) reporting systems.</p>
CW 29 (01/13)	<p><b><u>Applicant Test (Recommended Form)</u></b></p> <p>This form will replace the QR 29 as soon as administratively possible, and no later than upon implementation of SAR. The use of this form</p>

has not changed. This form is used to determine if the applicant passes the intake financial eligibility test. This form was updated to change the designation from a QR form to a CW form so that it can be used under QR, SAR or AR/CO reporting systems.

**CW 31 SAR (04/13)**

**Receipt for Documents (Recommended Form)**

This form will replace the current version of the CW 31 upon implementation of SAR. The use of this form has not changed. This form is used as a receipt for any documents that clients turn into the county. This form was updated to correct the references to outdated forms with the forms that will be used under SAR and AR/CO.

**CW 2103 (02/13)**

**Reminder for Teens (Required Form, Substitutes Permitted)**

This form will replace the QR 2103 as soon as administratively possible, and no later than upon implementation of SAR. The use of this form has not changed. This form is given to teens turning 18 years old to inform them under what circumstances they may continue to receive aid in their parent's case and if they may be able to start their own AU. The designation of this form was changed and it was updated to remove the reference to "quarter" so this form can be used under QR, SAR or AR/CO reporting systems. This form was further amended to add a bullet stating that: if you are 18 years old and pregnant, and don't have other children, you may be able to get cash aid once your pregnancy is verified, if you are not otherwise eligible for the Cal-Learn program.

**SAR 3 (04/13)**

**Mid-Period Status Report (Recommended Form)**

This form will replace the QR 3 upon implementation of SAR. The use of this form has not changed. This form is used by clients to report mandatory or voluntary changes that have occurred since they last reported. This form was updated to change references from Food Stamps to CalFresh; to clarify that reporting income over the Income Reporting Threshold is now a mandatory report for both CalWORKs and CalFresh households; to make separate bullets to report fleeing felons or parole/probation violations; to give clients a place to report that they have become homeless; and to define ABAWDs.

**SAR 7 Addendum  
(04/13)**

**Instructions and Penalties for the Eligibility Status Report  
(Required Form, Substitutes Permitted)**

This form will replace the QR 7 Addendum upon implementation of SAR. The use of this form has not changed. This form is used to help clients complete their SAR 7 by giving them examples of types of income, property, housing costs, and expenses. This form also informs clients of the penalties for cash aid and CalFresh fraud. This form was updated to change references from Food Stamps to CalFresh and to add a definition of gross income.

**SAR 22 (03/13)**

**Sponsor's Statement of Facts (Mandatory Form, Substitutes Permitted)**

The SAR 22 will replace the QR 22 upon implementation of SAR. This form is a mandatory supplement to the SAWS 2 for sponsored noncitizens to deem the sponsor's income and resources. This form was updated with technical changes and language clarifications; SAR

reporting requirements were explained on the coversheet; and an additional question was added regarding any anticipated changes in income.

**SAR 23 (03/13)**

**Senior Parent Statement of Facts (Required Form, Substitutes Permitted)**

This form will replace the CW 23 upon implementation of SAR. This form is a mandatory supplement to the SAWS 2 for minor parent's to deem the senior parent's income and resources. This form was updated with technical changes and an additional question was added regarding any anticipated changes in income.

**SAR 72 (03/13)**

**Sponsor's Semi-Annual Income and Resources Report (Required Form, Substitutes Permitted)**

This form will replace the QR 72 upon implementation of SAR. The use of this form has not changed. This form was updated to more closely mirror the SAR 7 in the manner that it asks about income, resources, and other changes since the sponsor last reported. It was also updated to ask about any known changes in the next six months.

**SAR 73 (03/13)**

**Senior Parent's Semi-Annual Income Report (Required Form, Substitutes Permitted)**

This form will replace the QR 73 upon implementation of SAR. The use of this form has not changed. This form was updated to more closely mirror the SAR 7 in the manner that it asks about income, resources, and other changes since the senior parent last reported. It was also updated to ask about any known changes in income in the next six months.

**SAWS 2 (04/13)**

**Statement of Facts (Required Form, Substitutes Permitted)**

This form will replace the current version of the SAWS 2 as soon as administratively possible, and no later than upon implementation of SAR. The SAWS 2 will still be used as the application and redetermination/recertification for CalWORKs, CalFresh, and Medi-Cal; however, under SAR, the SAWS 2 will take the place of the second semi-annual eligibility report and under AR/CO, the SAWS 2 will be the only required eligibility report per year. This form was updated with technical changes; question 6 regarding Foster Care was updated to ensure Foster Care children are presented with all of their health care options; question 20 was updated to ask if the reported income is expected to continue in order to reasonably anticipate income and calculate benefits for the upcoming payment period; question 20 was also updated to give clients a place to report the anticipated start date of a new job; a bullet was added to question 25 asking about any jobs the county helped the client to get as a prompt to help determine if former CalWORKs recipients became ineligible for cash aid due to AB 98 Subsidized Employment income; question 47 was split up into two questions: one about fleeing felons and one about parole or probation violations; and the reference to SFIS was removed in regards to CalFresh.

**SAWS 2A SAR (04/13) Rights, Responsibilities And Other Important Information For The Cash Aid And CalFresh Programs, And/Or Medi-Cal/34-County Medical Services Program (CMSP) (Required Form, No Substitute Permitted)**

This form will replace the SAWS 2A QR upon implementation of SAR. The use of this form has not changed. This form has been modified for use under SAR and AR/CO; technical changes were made; CalFresh rules regarding providing social security numbers and citizenship information were updated; SAR and AR/CO reporting and budgeting rules were explained in detail; instructions regarding fingerprinting and photo imaging were revised to clarify that these rules only apply to cash aid; it was clarified that a person must have been found by a court of law to be in violation of probation or parole; the ABAWD acronym was replaced with a description of this population; the earned income disregard was changed back to \$225 because it will be restored to that level effective October 1, 2013 when SAR will be implemented; property limits for aged and disabled were updated from \$3000 to \$3250 (to match the CalFresh property limits as explained in ACIN I-62-11E); and the amount of benefits wrongly paid out resulting in a felony was updated from \$400 to \$950.

**NOTE:** The CW 30 CalWORKs Budget Worksheet, will be revised for use under SAR and AR/CO and will be released shortly in the ACL transmitting the implementation instructions regarding reinstating the \$225 Earned Income Disregard, effective October 1, 2013.

**STATEMENT OF FACTS FOR AN ADDITIONAL PERSON**

*(Supplemental Application for CalFresh 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 "CF" for CalFresh 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 CalFresh 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)  
 CF

VERIFIED:	YES	NO
SSN		
CF ID		
Blind/Deaf/Disabled Residency		
DFA 285-C Comp.		
CW 25 Completed		
QR 25 A Completed		
Referred to WTW		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		

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

NAME (First Middle Last)	CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National	
	<input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
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
MARITAL STATUS	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Currently Attending School
<input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated		<input type="checkbox"/> Not Attending School (Explain):
<input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed		
RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD?	ANY OTHER NAME USED: (Maiden, adoptive, etc.)	
If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO		

Date of Entry to U.S. \_\_\_\_\_  
 Excluded HH Member Code \_\_\_\_\_  
 Work/Training/WTW Code \_\_\_\_\_

TYPE OF AID REQUESTED (✓)  Cash Aid  CalFresh

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

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

PARENT OR CARETAKER RELATIVE'S NAME (✓) Lives in Home	OTHER PARENT'S NAME (✓) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply)
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Absence
<input type="checkbox"/> No	<input type="checkbox"/> No		<input type="checkbox"/> Unemployment
			<input type="checkbox"/> Incapacity
			<input type="checkbox"/> Death

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?  YES  NO  
 CF If "YES", explain:

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

CA ⑥ Does he/she presently live in California and intend to continue living here?  YES  NO  
 CF If "NO", explain:

CA ⑦ Is he/she a foster child living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO CF A. Was the child placed in your home under a dependency order from the court? <input type="checkbox"/> YES <input type="checkbox"/> NO B. Do you want the foster child and foster care income counted on the CalFresh case? <input type="checkbox"/> YES <input type="checkbox"/> NO C. Is the child enrolled in a health care plan? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>COUNTY USE ONLY</b> 7A: <input type="checkbox"/> Request dependency order 7B: CA and FC Elig/CR Chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP 7C: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Fee for Service												
CA ⑧ A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO CF	VERIFIED: School Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No CF Eligible Student <input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM</td> <td style="width: 25%;">UNITS/HOURS PER WEEK</td> <td style="width: 25%;">EXPECTED DATE OF GRADUATION</td> <td style="width: 25%;">WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="4">IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time    <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):</td> </tr> </table>	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):				VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> 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. CF	VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter</td> <td style="width: 25%;">TUITION/FEES PER TERM \$</td> <td style="width: 25%;">BOOKS, EQUIPMENT, ETC., PER TERM \$</td> <td style="width: 25%;"></td> </tr> <tr> <td>ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)</td> <td>DAYS ATTENDING PER WEEK</td> <td colspan="2">TRANSPORTATION USED</td> </tr> <tr> <td>TRANSPORTATION COST PER WEEK \$</td> <td>AMOUNT PAID BY CARPOOL MEMBERS \$</td> <td colspan="2">PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$</td> </tr> </table>	TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$		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 \$		VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No
TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$											
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 ⑨ Has he/she had cash aid or CalFresh 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? <input type="checkbox"/> YES <input type="checkbox"/> NO CF If "YES", complete below:	WHY WHEN WHAT COUNTY/STATE												
CA ⑩ Is any member of the household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? If "YES", give name of the person: <input type="checkbox"/> YES <input type="checkbox"/> NO CF	CA ⑪ Has any member of the household been found by a court of law to be in violation of probation or parole? If "YES", give name of the person: <input type="checkbox"/> YES <input type="checkbox"/> NO CF												
CA ⑫ 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 cash aid, for convictions on or after 1/1/98; and for CalFresh, for crimes and convictions after 8/22/96. If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO CF	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">NAME OF PERSON CONVICTED</td> <td style="width: 33%;">DATE CONVICTED</td> <td style="width: 33%;">DATE CRIME COMMITTED</td> </tr> </table>	NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED									
NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED											
CF ⑬ Does he/she regularly buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO	Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No												
CF ⑭ Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO	Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No												
CF ⑮ Does he/she pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">Household Elects</td> </tr> <tr> <td style="width: 33%;">BOARDER</td> <td style="width: 33%;">HH MEMBER</td> <td style="width: 33%;">ROOMER</td> </tr> </table>	Household Elects			BOARDER	HH MEMBER	ROOMER						
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BOARDER	HH MEMBER	ROOMER											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">CHECK (✓)</td> <td style="width: 25%;">HOW MUCH</td> <td style="width: 25%;">HOW OFTEN</td> <td style="width: 25%;">NO. OF MEALS PER DAY</td> </tr> <tr> <td><input type="checkbox"/> Meals    <input type="checkbox"/> Room    <input type="checkbox"/> Both</td> <td>\$</td> <td></td> <td></td> </tr> </table>	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$			CF ⑯ Does he/she get food from any of the following programs? <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> <li>● Communal dining facility for the elderly or disabled</li> <li>● Food distribution program operated by a Native American reservation</li> <li>● Other food program</li> </ul> If "YES", complete below:				
CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY										
<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$												
NAME OF PROGRAM	NAME OF PROGRAM												

CA CF	<b>17</b> Is he/she working now or expecting to be working in the future? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below. Attach paystubs or other proof of earnings. If job hasn't started what is the anticipated start date? _____ (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).	<b>COUNTY USE ONLY</b>																								
EMPLOYER NAME _____ SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO OCCUPATION _____ DAYS/HOURS WORKED PER MONTH _____		<input checked="" type="checkbox"/> if Exempt <input type="checkbox"/> CA <input type="checkbox"/> CF Adult <input type="checkbox"/> CF Child CF S/E Farmer <input type="checkbox"/> Yes <input type="checkbox"/> No																								
PAY DATE(S) _____ WAGES BEFORE DEDUCTIONS \$ _____ per _____ TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO																										
Will this income continue? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain any changes here: _____		Verification(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No																								
CA CF	<b>18</b> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	Child Care Informing Given to Client:																								
NAME OF PERSON WHO RECEIVES CARE _____ NAME OF PERSON WHO GIVES CARE _____ MONTHLY AMOUNT PAID \$ _____		Trustline Informing (CCP 2) _____ Health & Safety Certification (CCP 5) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No																								
NAME OF PERSON WHO RECEIVES CARE _____ NAME OF PERSON WHO GIVES CARE _____ MONTHLY AMOUNT PAID \$ _____		Dependent Care Eligible CA _____ CF _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No																								
CA CF	<b>B.</b> Does he/she get child care costs paid for them? <input type="checkbox"/> YES <input type="checkbox"/> NO Include costs paid by a relative or friend, Department of Education, Student Aid, Block Grant, Cal-Learn, TCC, NET, WTW, SCC, CAAP, etc. If "YES", complete below:																									
NAME OF CHILD _____ WHO PAYS _____ MONTHLY AMOUNT PAID \$ _____																										
NAME OF CHILD _____ WHO PAYS _____ MONTHLY AMOUNT PAID \$ _____																										
CA CF	<b>19</b> Has he/she stopped or refused work or training in the last 60 days? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"></td> <td style="width:10%; text-align: center;">YES</td> <td style="width:10%; text-align: center;">NO</td> </tr> <tr> <td>Emp. Statement</td> <td></td> <td></td> </tr> <tr> <td>Good Cause Determ</td> <td></td> <td></td> </tr> <tr> <td>Voluntary Quit</td> <td></td> <td></td> </tr> </table>		YES	NO	Emp. Statement			Good Cause Determ			Voluntary Quit														
	YES	NO																								
Emp. Statement																										
Good Cause Determ																										
Voluntary Quit																										
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM _____ Did this person get or expect to get wages or benefits this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below.		<input type="checkbox"/> CA: 30 days <input type="checkbox"/> CF: 60 days																								
LAST PAYCHECK RECEIVED (DATE) _____ AMOUNT BEFORE DEDUCTIONS \$ _____																										
EXPECTED CHECK (DATE) _____ AMOUNT BEFORE DEDUCTIONS \$ _____																										
NUMBER OF HOURS OF WORK/TRAINING _____ LAST DAY OF WORK/TRAINING _____ TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO Last Month _____ REASON FOR LEAVING JOB/TRAINING _____ This Month _____																										
CA CF	<b>20</b> Is he/she on strike? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	Striker Regs Apply CA _____ CF _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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 \$ _____																										
CF	<b>21</b> Does he/she pay child or spousal support? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	Court Order on File <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Ordered \$ _____																								
NAME OF CHILD OR SPOUSE _____ AMOUNT PER MONTH \$ _____ COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO																										
CA CF	<b>22</b> 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.? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:																									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">TYPE BENEFIT</th> <th style="width:10%;">AMOUNT</th> <th style="width:10%;">DATE APPLIED</th> <th style="width:10%;">WHERE (COUNTY/STATE)</th> <th style="width:10%;">DATE LAST RECEIVED</th> <th style="width:10%;">HOW OFTEN (Weekly, Monthly, Etc.)</th> <th style="width:10%;">DATE EXPECTED TO START AND STOP</th> <th style="width:10%;">(✓) if Exempt</th> </tr> </thead> <tbody> <tr> <td> </td> <td>\$</td> <td> </td> <td> </td> <td> </td> <td> </td> <td>START: _____</td> <td>CA _____ CF _____</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td>STOP: _____</td> <td> </td> </tr> </tbody> </table>		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: _____	CA _____ CF _____							STOP: _____		
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: _____	CA _____ CF _____																			
						STOP: _____																				
Will this income continue? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain any changes here: _____																										

CA 23 Does he/she own or is he/she buying any real estate, such as land  YES  NO  
 CF and/or buildings anywhere, including outside the U.S.?  
 If "YES", complete below:

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

**COUNTY USE ONLY**

Home Exempt  Yes  No

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

CA 24 A. Does he/she have any of the following resources?  YES  NO  
 CF 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  
 CA CF

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

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA 25 Does he/she own, lease, or use any motor vehicles, such as a  YES  NO  
 CF car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.?  
 If "YES", complete below:

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	\$	\$

(✓) If Exempt Leased  Exempt  Leased  
 Vehicle Valuation

CA 26 Does he/she own or use personal property which cost at least \$100 for  YES  NO  
 CF 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.  
 If "YES", complete below:

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

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

CA 27 Has he/she sold, transferred or given away any real or personal property  YES  NO  
 CF within the last 2 years for cash aid and within the last 3 months for CalFresh?  
 If "YES", explain below:

Closed Bank Accounts:  
 CalFresh in last 3 months

CA 28 Does he/she have any of the following insurance coverage: life, burial,  YES  NO  
 CF disability or mortgage?  
 If "YES", complete below:

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

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

CA 29 Does he/she have health or hospitalization insurance, including insurance  YES  NO  
 CF paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.?  
 If "YES", complete below:

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

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

CA 30 Did he/she get medical/ pregnancy treatment this month or in the three months before this month? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", complete below:	<b>COUNTY USE ONLY</b>																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th rowspan="2" style="width:30%;">NAME OF PERSON RECEIVING CARE</th> <th rowspan="2" style="width:15%;">MONTHS OF CARE</th> <th colspan="2" style="width:20%;">WAS PAYMENT MADE FOR TREATMENT?</th> <th colspan="2" style="width:15%;">WANT MEDI-CAL FOR THOSE MONTHS?</th> </tr> <tr> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?		YES	NO	YES	NO													Retro Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No Approved <input type="checkbox"/> Yes <input type="checkbox"/> 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 31 Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", complete below:	<input type="checkbox"/> DHS 6155																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">NAME OF INSURANCE COMPANY</th> <th style="width:35%;">PREMIUM AMOUNT</th> <th style="width:35%;">HOW OFTEN PAID</th> </tr> <tr> <td> </td> <td>\$</td> <td> </td> </tr> <tr> <td> </td> <td>\$</td> <td> </td> </tr> </table>	NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID		\$			\$																							
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	\$																														
	\$																														
CA 32 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? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", complete below:	VERIFIED: Higher/Lower MAP <input type="checkbox"/> Yes <input type="checkbox"/> No Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C																														
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CA 33 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? CF Check (✓) each item YES or NO:	CA Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____ VERIFIED: CA <input type="checkbox"/> Yes <input type="checkbox"/> No CF <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> </tr> <tr> <td>Special diet--prescribed by a doctor</td> <td> </td> <td> </td> <td>Very high use of utilities</td> <td> </td> <td> </td> </tr> <tr> <td>Special transportation need</td> <td> </td> <td> </td> <td>Special laundry service</td> <td> </td> <td> </td> </tr> <tr> <td>Special telephone or other equipment</td> <td> </td> <td> </td> <td>Other (specify):</td> <td> </td> <td> </td> </tr> <tr> <td>Housework (no one in the home can do it)</td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> If "YES", explain:		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)						
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Housework (no one in the home can do it)																															
CA B. Does he/she get In-Home Supportive Services (IHSS)? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> CF If "YES", how much does he/she pay each month? \$ _____	<input type="checkbox"/> DFA 285-C																														
CA 34 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.	<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> 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.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:50%;">YES</th> <th style="width:50%;">NO</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>	YES	NO																												
YES	NO																														
<ul style="list-style-type: none"> <li>• Do you want more information about CHDP Services? .....</li> <li>• Do you want CHDP medical services? .....</li> <li>• Do you want CHDP dental services? .....</li> <li>• Do you need help making appointments or with transportation to CHDP Services? .....</li> </ul>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td> </td> <td> </td> </tr> </table>																														
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?	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td> </td> <td> </td> </tr> </table>																														
C. Is anyone in the family breastfeeding a child? .....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td> </td> <td> </td> </tr> </table>																														
If "YES", was the birth within the last 12 months? .....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td> </td> <td> </td> </tr> </table>																														
If you checked "YES" to 33 B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.	<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral																														
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.  Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.	<input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date _____																														

## CERTIFICATION

### I understand that:

- 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, school attendance, etc. And for cash aid and CalFresh, records will be matched with law enforcement agencies for arrest warrants.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state, and federal personnel, and if I gave wrong facts, my cash aid, CalFresh, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and 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 U.S. Citizenship and Immigration Services (USCIS) to verify immigration status and the facts the county gets from USCIS may affect my eligibility for cash aid, CalFresh and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident alien (LPR), (b) an amnesty alien with a valid and current I-688, or (c) an alien permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the USCIS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The CalFresh household, any adult member of a CalFresh household (even if he/she moves out), the sponsor of a noncitizen 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 to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime or has been found by a court of law to be in violation of their probation or parole cannot get cash aid or CalFresh.
- Anyone who has committed and been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) since August 22, 1996, cannot get CalFresh or if convicted on or after January 1, 1998, cannot get cash aid.
- For cash aid, the county will require that I and certain household members be fingerprint and photo imaged. Benefits may be denied or stopped if we do not cooperate.

### I also understand that:

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

#### For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years. And 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; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
  - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
  - For conviction of felony thefts 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.
  - 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 false proof 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: forever.

#### For CalFresh:

- If on purpose I do not follow CalFresh rules, my CalFresh benefits will 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 CalFresh benefits for firearms, ammunition, or explosives, my CalFresh can be stopped forever for the first violation.
  - I traded or sold CalFresh benefits for controlled substances, my CalFresh can be stopped for 24 months for the first violation and forever for the second.
  - I traded or sold CalFresh benefits that were worth \$500 or more, my CalFresh can be stopped forever.
  - I filed two or more applications for CalFresh at the same time and gave the county false identity or residence information, my CalFresh can be stopped for 10 years.

**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, MEDI-CAL APPLICANT, ADULT CALFRESH HOUSEHOLD MEMBER OR CALFRESH AUTHORIZED REPRESENTATIVE)

SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)

DATE

SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY

DATE

# STATEMENT OF FACTS TO ADD A CHILD UNDER AGE 16

(Supplemental Application and Request for Cash Aid and/or CalFresh)

## INSTRUCTIONS:

Fill out this form for a new child in the home and sign the Certification section. If you need more space, attach another sheet of paper. Use one form for each child.

If you get Cash Aid, and you want aid for the new child, this form must be filled out by the parent or California domestic partner or adult caretaker relative.

For CalFresh households which do not get or want to get Cash Aid, this form must be filled out by an adult household member or authorized representative.

### COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME AND NUMBER

DATE RECEIVED

CHILD NEEDS AID DUE TO PARENT'S (✓) BELOW

DEATH	DISABILITY	ABSENCE	UNEMPLOYMENT
-------	------------	---------	--------------

1. Parent's or Caretaker Relative's Name Phone ( )

## 2. Give us all the facts for this child.

CHILD'S NAME (FIRST, MIDDLE, LAST) PARENT OR CARETAKER RELATIVE'S NAME

SOCIAL SECURITY NUMBER SEX (✓)  M  F OTHER PARENT'S NAME

BIRTHPLACE (CITY/STATE/COUNTRY) BIRTHDATE (MONTH, DAY, YEAR) BLIND, DEAF, OR DISABLED  YES  NO

TYPE OF AID REQUESTED (✓)  Cash Aid  CalFresh CITIZEN/NONCITIZEN STATUS (✓)  U.S. Citizen/National  Noncitizen: Sponsored  YES  NO

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE IF CHILD IS UNDER AGE 6, ARE IMMUNIZATION SHOTS UP TO DATE?  YES  NO  Not under age 6

3. Is the child a foster child?  YES  NO  
 A. Was the child placed in your home under a dependency order from the court?  YES  NO  
 B. Do you want the foster child and foster care income counted on the CalFresh case?  YES  NO  
 C. Is the child enrolled in a health care plan?  YES  NO

4. Did the child get cash aid or CalFresh this month?  YES  NO  
 If "YES", complete below:

TYPE OF AID  Cash Aid  CalFresh WHERE (County, State)

5. Does the child get or expect to get any income, such as: Earnings, Supplemental Security Income/State Supplementary Payment (SSI/SSP), Social Security Benefits, Child Support, Foster Care Payment, Veterans Benefits, etc. If "YES", complete below:  YES  NO

TYPE OF INCOME	AMOUNT (Before Deductions, if any)	WHEN	HOW OFTEN
	\$		

Will this income continue?  YES  NO If "NO", explain any known changes:

6. A. Complete below if you want cash aid for this child and the child is between ages 6 to 16. Does he/she attend school regularly?  YES  NO  Not Age 6-16  
 If "NO", explain why he/she does not attend regularly:

B. Is the child pregnant or a teen parent?  YES  NO  
 If "YES", Check (✓) status:  Pregnant  Teen Parent

SCHOOL STATUS, CHECK (✓)  Has a High School Diploma  Has a GED  Not Attending School (explain):  
 Currently Attending School  Other (explain):

C. Has the child received a cash bonus or sanction, or help with child care, transportation, etc. from the Cal-Learn Program?  YES  NO  
 If "YES", complete below:

WHERE (COUNTY) DATE(S) RECEIVED

7. Has the parent(s) of this child been in the United States (U.S.) military?  YES  NO  
 If "YES", complete below:

NAME OF PARENT	PARENT A U.S. CITIZEN	BRANCH OF SERVICE	DATES OF SERVICE	HONORABLE DISCHARGE
	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO

## 8. Complete below if you want CalFresh for this child and the child is not a citizen of the U.S.

A. How many years total has this child and/or his/her parents lived in the U.S.?  
 B. While living in the U.S., in how many of the years did this child and/or the child's parents earn money by working in the U.S.?  
 C. While living outside the U.S., how many total years did this child and/or the child's parents work in the U.S. or for a U.S. company?

AU	Non-AU	MFG Child <input type="checkbox"/> Yes <input type="checkbox"/> No	CF Non-HH Excl. Member Code:
----	--------	--	------------------------------

Work Registration/Exemption Codes:

WtW: CF:

VERIF:  SSN  Blind/Deaf/Disabled Citizen  SAVE  Eligible Noncitizen  Immun.

Alien Reg. No. D.O.E.

3A.  Request dependency order  
 3B.  CA and FC Elig/CR Chooses: Child:  CA  FC CR:  CA  None  Kin-GAP  
 3C.  Medi-Cal  Fee for Service

Verification provided

Verification provided  
 FC Income Counted on CF Case  YES  NO  
 CA Eligible for Higher MAP

Income		(✓) if exempt	
Unearned	Earned	CA	CF

Verified:  Referred to Cal-Learn Program  
 CW 25  
 QR 25A

CW 5  YES  NO  
 Date Initiated \_\_\_\_\_

CF: Honorable Discharge  YES  NO

<b>9. Does the child own any property or have resources, such as: cash, land, bank accounts, trust funds, savings bonds, Native American per capita payments or trust funds, or other items? If "YES", complete below:</b>				<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>COUNTY USE ONLY</b>
TYPE OF RESOURCE	ACCOUNT/POLICY NUMBER	NAME, ADDRESS OF BANK, ETC.	CURRENT VALUE	<input type="checkbox"/> Verification provided <input type="checkbox"/> CA Restricted Account <input checked="" type="checkbox"/> Check if exempt <input type="checkbox"/> CA <input type="checkbox"/> CF	
<b>10. Does the child have Medicare or health insurance, such as Blue Cross, Kaiser, CHAMPUS, etc., which is paid for by a parent or parent's employer? If "YES", list insurance coverage:</b>				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Verification provided Health Coverage Code:
<b>11. Has the child been charged as an adult with a felony, and if so, is the child hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for that felony crime or attempted felony crime?</b>				<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>12. Has the child been found by a court of law to be in violation of probation or parole?</b>				<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>13. Has the child been convicted as an adult of a drug-related felony for possession, use, or distribution of a controlled substance(s)? If "YES", give facts for cash aid, for convictions on or after 1/1/98; and for CalFresh, for crimes and convictions after 8/22/96.</b>				<input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE CONVICTED		DATE CRIME COMMITTED			

<b>14. A. If you can get cash aid, eligible members of your family under age 21 may be able to get some health examinations through the Child Health and Disability Prevention Program (CHDP).</b>			<b>YES</b>	<b>NO</b>	<input type="checkbox"/> CHDP brochure and explanation given <input type="checkbox"/> CHDP Referral <input type="checkbox"/> Date:
• Do you want more facts about CHDP services?.....					<input type="checkbox"/> Referred for Immunization
• Do you want free CHDP medical or dental services?.....					<input type="checkbox"/> Other services referral
• Do you need help making appointments or getting to the doctor or dentist?.....					<input type="checkbox"/> Pregnant
<b>B. Do you want more facts about immunization services? .....</b>					<input type="checkbox"/> Parent or Guardian of child under 5
<b>C. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs? .....</b>					<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum
<b>D. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help? .....</b>					<input type="checkbox"/> WIC referral
<b>E. Is anyone breastfeeding a child? .....</b> If "YES", was the birth within the last 12 months? .....					<input type="checkbox"/> Family Planning info given Date Referred:
<b>F. Do you want to get facts or services from a Family Planning Clinic to help you plan your family size and prevent unplanned pregnancies? .....</b>					

**CERTIFICATION**

**I understand that:**

- If I give wrong facts or fail to report all facts or situations on purpose that affect my eligibility and aid payments, I may be fined, jailed/imprisoned, or both. I can be fined up to \$10,000 for cash aid and \$250,000 for CalFresh. I can be sent to jail/prison for up to 3 years for cash aid and 20 years for CalFresh. And benefits for cash aid and CalFresh can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, 20 years or forever; and for Refugee Cash Assistance, 3 months and 6 months.
- My case can be picked for reviews to prove eligibility; and I must cooperate fully with county, state, and federal personnel in any quality control review.
- The facts I give will be checked out by local, state, and federal personnel.
- The county will send facts to the U.S. Citizenship and Immigration Services (USCIS) for proof of immigration status.
- The facts the county gets from USCIS may affect eligibility for cash aid and CalFresh.
- The facts I give will be checked with tax, welfare, employment agencies, school districts, and the Social Security Administration to prove the child's eligibility for cash aid and/or CalFresh and to prove that I am getting the right amount of cash aid or CalFresh. And the social security number will be matched with law enforcement agency records for arrest warrants.

**I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this Statement of Facts is true, correct, and complete.**

**WHO MUST SIGN THIS FORM:** For Cash Aid, you and your aided spouse, Registered Domestic Partner, or the other parent (of cash aided children), if living in the home.  
 For CalFresh, an adult household member or authorized representative.

SIGNATURE OF CARETAKER RELATIVE AND/OR ADULT CALFRESH HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE	DATE
SIGNATURE OF CASH-AIDED SPOUSE OR DOMESTIC PARTNER OR OTHER PARENT (OF CASH-AIDED CHILD) IF LIVING IN THE HOME	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

**COUNTY USE ONLY**

<input type="checkbox"/> INELIGIBLE (Reason)				IMMUNIZATION	
<input type="checkbox"/> ELIGIBLE				<input type="checkbox"/> Informing (CW 101 / TEMP CW 101A)	
Eligibility Conditions Met - Date:		Authorization Date:		Effective Date of Aid:	
Signature of County Worker		Date		Signature of Supervisor	
				Date	

# PAYEE AGREEMENT FOR MINOR PARENT

COUNTY USE ONLY	
CASE NAME:	
CASE NUMBER:	
WORKER NAME:	

If you do not return this form by \_\_\_\_\_ you will not get cash aid.

## SECTION A: PREGNANT OR PARENTING MINOR AGREEMENT

I understand that any cash aid I am eligible to get for myself or dependent child(ren) will be paid to my parent, legal guardian, or other adult relative, with whom I live. I give permission to give this agreement to the person named below.

NAME OF PROPOSED PAYEE	RELATIONSHIP
SIGNATURE OF MINOR	DATE

## SECTION B: PAYEE RESPONSIBILITIES

The above-named minor has applied for California Work Opportunity and Responsibility to Kids (CalWORKs) for him/herself and/or his/her dependent child(ren). The minor has named you to serve as payee and receive cash aid payments. Payee responsibilities are listed below:

- I understand the payments I get for the person(s) in this case are to be used for their support. If I willfully and knowingly receive or use any part of the payment for any reason other than to support them, state law says I may be prosecuted for committing a misdemeanor.
- I understand that I am responsible to make sure the minor is given all information sent to me by the county for the minor such as annual and semi-annual report forms, notices of action and informing notices. It is the minor's responsibility to complete any necessary forms by the due date.
- I understand that if the minor moves out of my home, I should notify the county within 5 days and any payments received after the minor moves out should be returned to the county.
- I understand that if I do not agree to become the payee it does not affect the eligibility of the minor and/or his/her dependent child(ren).

## SECTION C: PAYEE CERTIFICATION

Please check (✓) one of the boxes below:

- I understand the above facts and agree to act as the payee for the minor listed above.
- I refuse to act as the payee for the minor listed above.

PROPOSED PAYEE	PHONE NUMBER	DATE
----------------	--------------	------

# APPLICANT TEST

CASE NAME	CASE NUMBER	CASE WORKER NAME	DATE
-----------	-------------	------------------	------

- Determine whose needs to consider in the MBSAC size and select the corresponding MBSAC amount.
- Use a best estimate of countable income from AU members (including penalized AU members), certain non-AU members and sanctioned/excluded members.
- Deduct \$90 from the gross earned income of each family member whose earnings are used on the CW 29.
- Compare the family's total countable income to the MBSAC plus special needs to determine financial eligibility.

## MONTH AND YEAR \_\_\_\_\_

1. NUMBER OF FAMILY MEMBERS WHOSE NEEDS ARE CONSIDERED IN MBSAC	
2. CORRESPONDING MBSAC FOR FAMILY SIZE IN #1 ABOVE	\$
3. RECURRING SPECIAL NEEDS	+
4. TOTAL GROSS INCOME LIMIT	=
5. GROSS EARNINGS COMPUTATION	
a. Gross Earnings (Person 1)	\$
b. Disregard	- 90
c. SUBTOTAL	=
d. Gross Earnings (Person 2)	\$
e. Disregard	- 90
f. SUBTOTAL	=
g. Gross Earnings (Person 3)	\$
h. Disregard	- 90
i. SUBTOTAL	=
j. TOTAL (Line 5c, 5f and 5i)	\$
6. SOCIAL SECURITY BENEFITS	+
7. V.A. BENEFITS	+
8. UIB	+
9. CHILD/SPOUSAL SUPPORT RECEIVED (Less CSSD)	+
10. UA CONTRIBUTION (From CW 71)	+
11. UNEARNED IN-KIND (Total received)	+
12. ALL DISABILITY INCOME	+
13. OTHER (Specify)	+
14. TOTAL COUNTABLE INCOME (Line 5j through Line 13)	=
15. Is total countable income (Line 14) less than the total gross income limit (Line 4)?	
<input type="checkbox"/> YES; eligible, complete SAR 30.	
<input type="checkbox"/> NO; ineligible.	

SELF-EMPLOYMENT INCOME CALCULATION		
EARNINGS FROM SELF-EMPLOYMENT	PERSON 1 Line 5a	PERSON 2 Line 5d
Gross earnings from self employment	\$	\$
Expenses <input type="checkbox"/> Actual <input type="checkbox"/> 40%	-	-
Net self-employment income (Include in line 5 for appropriate person)	\$	\$

# RECEIPT FOR DOCUMENTS

CASE # (IF KNOWN) \_\_\_\_\_

COUNTY NAME	APPLICANT/RECIPIENT'S NAME	SOCIAL SECURITY NUMBER (OPTIONAL)
-------------	----------------------------	-----------------------------------

## THIS COUNTY RECEIVED THE FOLLOWING:

- SAR 3/AR 3/DFA 377.5 \_\_\_\_\_ MONTH
- SAR 7/MC 176 \_\_\_\_\_ MONTH
- Birth Certificate(s)
- Social Security Card Number Verification
- Citizenship/Non-Citizen Records
- Pregnancy Verification
- Pay Stub(s):
- Other: \_\_\_\_\_
- Report Cards/School Attendance Records
- Dependent Care Verification
- Rent Receipt
- Utility Bills
- Medical Bills
- Immunization Records

RECEIVED BY	TITLE	DATE RECEIVED

# REMINDER FOR TEENS TURNING 18 YEARS OLD

Give this notice right away to your child who will be turning 18 years old within the next 60 days.

## **If you are 18 years old and don't have children and/or are not pregnant**

You can still get cash aid as part of your parent/caretaker's case after your 18th birthday ONLY if you:

- Are a full-time student in high school, or in a vocational or technical training program, and are expected to finish school/program before reaching 19 years old, or
- Are a full-time student in high school, or in a vocational or technical training program, and have been or are considered disabled, and meet the disability criteria pursuant to the CalWORKs regulations, or
- Are a foster child living with an approved relative and are completing high school or an equivalency program, enrolling in post-secondary or vocational school, participating in a program or activity that promotes or removes barriers to employment, employed at least 80 hours per month, or unable to participate in school or employment due to a documented medical condition.

Call your county worker right away if you think you meet any of these situations. If you are eligible to stay on cash aid, you may need to have a fingerprint and photo image taken by the county.

## **If you are 18 years old and have a child of your own and/or are pregnant**

1. You can continue to get cash aid as part of your parent/caretaker's case after your 18th birthday ONLY if you:

- Are a full-time student in high school, or in a vocational or technical training program, and are expected to finish school/program before reaching 19 years old, or
- Are a full-time student in high school, or in a vocational or technical training program, and have been or are considered disabled, and meet the disability criteria pursuant to the CalWORKs regulations, or
- Are a foster child living with an approved relative and are completing high school or an equivalency program, enrolling in post-secondary or vocational school, participating in a program or activity that promotes or removes barriers to employment, employed at least 80 hours per month, or unable to participate in school or employment due to a documented medical condition.
- If you are 18 years old and pregnant, and don't have other children, you may be able to get cash aid once your pregnancy is verified, if you are not otherwise eligible for the CalLearn program.

**- OR -**

2. You can choose to start your own case. Call your county worker right away if you want to start your own case. Here are some things you need to know before starting your own case:

- You do NOT have to move out of your parent/caretaker's home to be in your own case.
- Your time limits for getting cash aid will start.
- As the head of your case, YOU must report all changes to your county worker.
- If you start your own case, your parent or caretaker may get less cash aid or if you are the only child their cash aid may be stopped.
- If you are 18 years old and pregnant, and don't have other children, you may be able to get cash aid once your pregnancy is verified, if you are not otherwise eligible for the CalLearn program.
- If the Maximum Family Grant (MFG) rule was applied to your child while you were a dependent minor parent, your child can be counted in your cash aid payment when you are in your own case.

If you are under your own case or are a part of your parent/caretaker's case, to be eligible to stay on cash aid, you may need to have a fingerprint and photo image taken by the county. If you have questions about whether you should start your own case, call the county welfare office or local legal services office.

**MID-PERIOD STATUS REPORT****For Cash Aid and CalFresh**

RECIPIENT'S NAME:

CASE NUMBER (IF KNOWN):

Use this form to report mandatory or voluntary changes that have occurred since you last reported.

If you are reporting income information, please provide proof, such as: pay stubs; copies of checks; letters from agencies; etc.

If you are reporting changes in expenses, please provide proof, such as: receipts; canceled checks; paid invoices; etc.

If you are reporting an address change, please provide proof of expenses such as: a copy of your new rental agreement or lease; rent receipt for your new address; copies of utility deposits; etc.

**MANDATORY INFORMATION**

**If you get Cash Aid, report the information marked CA. If you get CalFresh, report the information marked CF. Sections marked CA/CF are for all households/assistance units.**

CA/CF  My combined household income is more than the limit for my household size.  
In the month of \_\_\_\_\_, the total combined income for my household is \$ \_\_\_\_\_.

CA  Someone in my household was convicted of a felony drug charge.  
Name of person \_\_\_\_\_  
Date of felony conviction \_\_\_\_\_

CA  Someone in my household is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime.  
Name of person \_\_\_\_\_

CA  Someone in my household has been found by a court of law to be in violation of probation or parole.  
Name of person \_\_\_\_\_

CA  I have moved, changed my phone number or have a new mailing address.  
New home address \_\_\_\_\_  
New mailing address (if different from your home address) \_\_\_\_\_  
New phone number (\_\_\_\_\_) \_\_\_\_\_

- I get free rent at this new address.  
 My rent amount is \$ \_\_\_\_\_ per month.  
 I share the rent; my share is \$ \_\_\_\_\_.  
 I became homeless.

- I get free utilities at this new address.  
 My utilities are \$ \_\_\_\_\_ per month.  
I have:  Heating  Cooling  
 Water  Sewer  
 Garbage  Telephone  
 Other

**See other side**

**MANDATORY INFORMATION - continued**

CF  Fill out this section to report reduced work or training hours for Able-Bodied Adults without Dependents (ABAWDs). (ABAWDs are adults between 19 and 50 who are not caring for minor children.)

The number of hours worked or in training dropped below 20 hours a week or 80 hours a month to \_\_\_\_\_ hours per week or \_\_\_\_\_ hours per month.

Name of person(s) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Explain what happened \_\_\_\_\_

Date of change \_\_\_\_\_

**VOLUNTARY INFORMATION** (All households/Assistance Units)

I would like to report the following information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 charged with a crime. And, I may be charged with committing a felony if more than \$950 in cash aid and/or CalFresh is wrongly paid out.

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.

**WHO MUST SIGN BELOW:**

**For Cash Aid:** you and your aided spouse, Registered Domestic Partner, or the other parent (of cash aided children), if living in the home.  
**For CalFresh:** the head of household, household member or the household's authorized representative.

Signature or Mark	Date Signed	Home Phone	Contact Phone
Signature of Spouse, Registered Domestic Partner or other Parent of Cash Aided Children	Date Signed	Signature of Witness to Mark, interpreter or other person completing form	Date Signed

## INSTRUCTIONS AND PENALTIES

### SAR 7 ELIGIBILITY STATUS REPORT

#### For Cash Aid and CalFresh

Need Help? Call the County.

- If you do not send in a complete report including, but not limited to, answering all questions on the SAR 7 and attaching proof when we ask for it, your benefits may be delayed, changed, or stopped. **Attach a separate sheet of paper if needed.**
- Facts you report may result in your benefits going up, down, or being stopped.
- Send in your completed report by the 5th of the month after the report month. It is late after the 11th.

### Examples

#### Income

- Wages
- Vacation pay
- In-Home Supportive Services (IHSS)
- Child/spousal support
- Insurance or legal settlements
- Rental income and rental assistance
- Any government benefits
- State Disability Indemnity
- Self-Employment
- Tips
- Interest or dividends
- Strike benefits
- Tax refunds
- Unemployment
- Social Security
- Supplemental Security Income/State Supplementary Payment (SSI/SSP)
- Salary
- Income In-Kind, such as earned housing, free housing/utilities/clothing/food
- Gambling/Lottery winnings
- Cash, gifts, loans, scholarships
- Other private or government disability or retirement
- Workers Compensation
- Veterans or Railroad retirement

#### Property

- Motor vehicles
- EBT cash aid balance
- Home
- Checking
- Savings Bonds
- Land
- Savings
- Life insurance policies
- Trusts

#### Housing Costs

- Rent
- Utilities
- Mortgage
- Homeowners insurance
- Property taxes
- Garbage/trash collection fees

#### Expenses

- Medical expenses
- Health insurance premiums
- Child/dependent Care
- College tuition & supplies
- Mandatory school fees
- Child/spousal support
- Transportation
- Room & Board
- Housing costs

Gross income means the amount you get before deductions are taken out (Examples of deductions are: Taxes, Social Security or other retirement contributions, health care plan premiums, garnishments, etc.).

### Penalties

**PENALTIES FOR CASH AID FRAUD: If on purpose you do not follow Cash Aid rules, your Cash Aid can be lowered for a period of time and you may be fined up to \$10,000 and/or sent to jail or prison for up to 3 years.**

#### Your 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 offense, or forever for the third.
- For submitting one or more application to get aid in more than one case for the same time period: 2 years for the first conviction, 4 years for the second, and 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 CALFRESH FRAUD: If on purpose you do not follow CalFresh rules, your CalFresh benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to \$250,000 and/or sent to jail/prison for 20 years.**

- **If you are found guilty in any court of law or administrative hearing because:**
- You traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation.
- You traded or sold CalFresh benefits for controlled substances, your CalFresh benefits can be stopped for 24 months for the first violation and forever for the second.
- You traded or sold CalFresh benefits that were worth \$500 or more, your CalFresh benefits can be stopped forever.
- You gave the county false identify or residence information, so you can get CalFresh benefits in more than one case at the same time, your CalFresh benefits can be stopped for 10 years.

# SPONSORED NONCITIZENS APPLYING FOR OR RECEIVING CASH AID AND/OR CALFRESH

## Important Information For Noncitizens Sponsored By Individuals

**As a noncitizen who is sponsored by an individual(s), you must meet special rules to get Cash Aid and/or CalFresh.**

### The Special Rules Are:

- Your sponsor's income and resources will have to be reviewed to see if you can get benefits. Your sponsor must fill out the attached form. Both you and your sponsor must sign this form.
- If your application is approved, you and your sponsor will have to report your income and resources every six months to keep getting Cash Aid and CalFresh benefits. If your sponsor does not provide this information, your benefits may be changed or stopped. Family members who are not sponsored and are otherwise eligible can keep getting their benefits.
- **You are the person responsible for getting all the information requested to the county welfare department for both you and your sponsor. Let the county know if you need help.**
- If your sponsor has abandoned you (you don't know where they are or they don't help you out) you might still be able to get benefits.

## Important Information For Sponsors

The noncitizen you sponsor has applied for Cash Aid and/or CalFresh. If you signed an affidavit of support, State regulations require the county welfare department to review your income, resources, and property in deciding whether or not the noncitizen applicant can get benefits. Sponsorship is normally for an indefinite period of time. This form must be completed and signed by you under penalty of perjury. If you are living with your spouse or your spouse has signed an affidavit of support, your spouse's income, resources, and property are also counted.

If the noncitizen's application for Cash Aid is approved, **each semi-annual period (every six months)** you will have to report your income, resources, and property on either this form or on the Sponsor's Semi-Annual Income and Resources Report (SAR 72). The noncitizen will give you the report form. Your report must be completed and returned to the noncitizen immediately to ensure the noncitizen's continued eligibility. Each semi-annual period, resources and a portion of your income will be used to determine the noncitizen's continued eligibility and benefits.

If the noncitizen receives benefits to which he or she is not entitled because you failed to accurately report information, you and/or the noncitizen may have to repay these benefits.

# SPONSOR’S STATEMENT OF FACTS INCOME AND RESOURCES

*(Supplement to the SAWS 2, Application For CalFresh And Cash Aid)*

**INSTRUCTIONS:** PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOURSELF AND YOUR SPOUSE (IF LIVING TOGETHER OR IF SPOUSE HAS SIGNED AN AFFIDAVIT OF SUPPORT) AND RETURN IT TO THE NONCITIZEN IMMEDIATELY.

Noncitizen Name and Address


Proof may be needed to verify answers to the following questions. Attach proof when the form asks for it.

① YOUR NAME (FIRST, MIDDLE, LAST)	TELEPHONE NUMBER (     )
-----------------------------------	-----------------------------

HOME ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)

MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS)

② YOUR SPOUSE'S NAME (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT) (FIRST, MIDDLE, LAST)	HAS SPONSOR'S SPOUSE SIGNED AN AFFIDAVIT OF SUPPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

③ Do you or your spouse get assistance such as: CalWORKs/TANF/cash assistance, CalFresh/SNAP/food benefits or Supplemental Security Income (SSI)? If Yes, complete below:     Yes     No

Case Name	Date of Birth	Type of Assistance	County	State

If **both** you and your spouse get Assistance and the noncitizen is **not** applying for CalFresh, complete only the Certification section on Page 3 and return the form. For all others, go to Question ④ .

④ A. Have you or your spouse sponsored any other noncitizen’s entry into the United States?     Yes     No  
If Yes, complete below using the I-864, I-864A or the I-134:

Noncitizen Name	Noncitizen Address	Date of Admission to U.S.

B. Are any of the noncitizens listed in ④A receiving any type of assistance such as: CalWORKs, CalFresh or SSI?     Yes     No  
If Yes, complete below:

Type of Assistance	Date First Applied	County	State

⑤ Do you or your spouse have other persons who are claimed or could be claimed as dependents for federal income tax purposes?     Yes     No  
If Yes, complete below:

Name of Person(s)	Does Person Live With Sponsor
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>COUNTY USE ONLY</b>
CASE NAME: _____
CASE NO: _____
WORKER NO: _____

VERIFIED:

Letter on File

Verbal Communication

Other: \_\_\_\_\_

VERIFIED:

Affidavit of Support on File

I-864

I-864A

I-134

Other: \_\_\_\_\_

Verified

Verified

IRS Form 1040 Reviewed

Other: \_\_\_\_\_

Claimed     Yes     No

<b>6 Are you or your spouse currently employed?</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>If Yes, complete section below. Attach paystubs or other proof of earnings. If you or your spouse are self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.</b>							<b>COUNTY USE ONLY</b>		
Name	Name of Employer	Gross Pay (Before Deductions)	How Often Paid (Weekly, Monthly, etc.)	Commissions or tips	Number of Tax Dependents Claimed		Check if Exempt	Enter Date Viewed Pay Stubs	Other
		\$		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No		
		\$		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>7 Do you or your spouse receive or expect to receive any other income such as: Social Security, Unemployment/Disability Insurance, Child/Spousal Support, Veterans Benefits, etc?</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>If Yes, complete section below and attach proof of the income.</b>									
Name	Type of Income	Amount	How Often Received						
		\$							
		\$							
<b>8 Will there be any changes to this income in the next six months?</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>If Yes, list below what change is expected. Attach any proof you may have such as: a letter from an employer, benefit award letter, etc.</b>									
Whose income will change?	What income will change?	How and when will it change?							
<b>9 Do you or your spouse have any of the following resources? Check each item. If Yes, explain below.</b>									
Resource	Sponsor	Spouse	Resource	Sponsor	Spouse				
Checks or Money (At Home or Elsewhere)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trust Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Checking, Savings, Credit Union Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stocks, Bonds, Certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Notes, Mortgages, Trust Deeds, Sales Contracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Type of Resource	Owner	Current Value	Location (Home, Bank, Address, etc.)	Account Number	Check if Exempt				
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No				
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No				
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>10 Do you or your spouse own (or are you buying) any real property, such as: a house, land, building, etc. If Yes, complete section below:</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
Name	Type of Property	Address/Location	How Used? (Home, Rent, etc.)	Balance Owed	Value	Name of Mortgage Co.	Check if Exempt		
				\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Registration and Records Viewed	
				\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	1. _____ 2. _____	
<b>11 Do you or your spouse own or use or are you buying any motor vehicles, such as: a car, truck, boat, trailer, van, camper, motorcycle, etc. If Yes, complete section below:</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
Name	Year, Make, Model	License Number and State of Registration	Amount of current License Fee	Balance Owed	Check if Exempt				
					<input type="checkbox"/> Yes <input type="checkbox"/> No				
					<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>12 Do you or your spouse who receive income pay any court ordered support?</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>If Yes, enter the monthly amount \$_____ Who pays?_____</b>							<input type="checkbox"/> Verified		
<b>13 Do you or your spouse make support payments to other persons not living in your home?</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>If Yes, complete section below:</b>							<input type="checkbox"/> Verified		
Who Pays		To Whom Paid (Name)			Amount Paid				
					\$				
					\$				
					\$				
					\$				
<b>14 Do you or your spouse own or use personal property or resources such as: Jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, other household furnishings. If Yes, complete section below:</b> <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
Name	Name of Item	Date of Purchase	Purchase Price	Gift	Amount Owed	Net Market Value			
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		1. _____			
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		2. _____			
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		3. _____			
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		4. _____			

**CERTIFICATION**

- I understand that if on purpose I don't give the right facts or all the facts for the CalWORKs, CalFresh or cash-based Medi-Cal Programs, I can be punished and I can be legally accused of the crime of fraud. If I am found guilty of committing fraud, I can be fined up to \$10,000 for CalWORKs and \$250,000 for CalFresh. And, I can go to jail/prison for up to 5 years for CalWORKs and 20 years for CalFresh. In the CalWORKs and CalFresh Programs, my benefits can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years or forever.
- I understand that the information provided on this form may be verified by local, state and federal agencies.
- I understand that the noncitizen's case, including my statement, may be selected for an additional review to ensure that the noncitizen's eligibility was determined correctly.
- I understand that I may be required to repay any benefits which are overpaid because of incorrectly or incompletely reported information.

- If the noncitizen is applying for Cash Aid, both you and your spouse must sign the form. If the noncitizen is applying for CalFresh benefits only, either you or your spouse must sign the form.

**SPONSOR'S CERTIFICATION:**

- I understand that the term for Sponsorship is normally an indefinite period of time.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the above information contained on this statement of facts is true, correct, and complete.

SPONSOR'S SIGNATURE OR MARK	DATE
SPONSOR'S SPOUSE'S SIGNATURE OR MARK (IF LIVING WITH SPOUSE OR SPOUSE HAS SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

- If the noncitizen is applying for Cash Aid, the noncitizen must sign this form. If the noncitizen is applying for CalFresh only, the form must be signed by the noncitizen, the head of household, a household member, or an authorized representative.

**NONCITIZEN'S CERTIFICATION:**

- I have reviewed this signed and completed form from my sponsor(s). I declare under penalty of perjury under the laws of the United States of America and the State of California that it is true, correct, and complete to the best of my knowledge.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

**COUNTY USE ONLY**

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources	CalWORKs Sponsor/Sponsor's Spouse Income Computation	CalFresh Sponsor/Sponsor's Spouse/Registered Domestic Partner Computation																																																																																							
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WORKER SIGNATURE	WORKER SUPERVISOR	DATE
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# SENIOR PARENT STATEMENT OF FACTS

(Supplement to the SAWS 2)

CASE NAME
CASE NUMBER

The rules say that when a minor parent (up to age 18) applies for cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

**INSTRUCTIONS:**

- Fill in this form and return it with your SAWS 2. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete form, your cash aid and cash-based Medi-Cal may be **changed or stopped**.
- If you have questions, ask your worker or call the county.

1. Does your parent(s) get income, money, or benefits, such as: Earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; interest or dividends from stocks, bonds, savings accounts; In-Home Supportive Services (IHSS); child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc.? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>			
NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		\$	
NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		\$	
2. Will there be any changes to this income in the next six months? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", list below what change is expected. Attach any proof they may have such as: a letter from an employer, benefit award letter, etc.			
WHOSE INCOME WILL CHANGE?	WHAT INCOME WILL CHANGE?	HOW AND WHEN WILL IT CHANGE?	
3. Does your parent(s) support other persons living in the home and claim them as Federal tax dependents? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", list name of person(s) and relationship.			
NAME	RELATIONSHIP	NAME	RELATIONSHIP
4. Does your parent(s) support anyone not living in the home and claim or could claim that person as a Federal tax dependent? If "YES", give name of person(s), amount paid and ATTACH PROOF. <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>			
NAME	AMOUNT PAID	NAME	AMOUNT PAID
	\$		\$

**CERTIFICATION**

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I get more than \$950 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to \$10,000 and/or sent to jail or prison for up to 3 years.
  - I understand that failing to report information or true facts can result in legal prosecution with penalties of a fine, imprisonment or both.
  - I understand that I must call my worker to report any unexpected changes which may affect my eligibility for or the amount of my Cash Aid within 5 days of the change. If I am unsure about needing to report any changes, I must contact my worker.
  - I understand that the facts I report may result in my benefits being denied, lowered or stopped.
  - I understand that I have the right to request a State Hearing on any proposed action by the County Welfare Department.
- 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.

**YOU MUST SIGN AND DATE THIS REPORT OR IT WILL BE INCOMPLETE**

SIGNATURE OF CASH AIDED MINOR PARENT

DATE SIGNED

COUNTY USE ONLY

**REPORT MONTH:** \_\_\_\_\_

**SPONSOR'S SEMI-ANNUAL INCOME AND RESOURCES REPORT (Supplement to the SAR 7)**

TO KEEP YOUR BENEFITS COMING ON TIME, PLEASE GIVE THIS FORM TO YOUR SPONSOR. YOU AND YOUR SPONSOR(S) MUST SIGN AND DATE THIS FORM AFTER THE LAST DAY OF THE REPORT MONTH AND RETURN IT BY THE 5th of (MONTH) WITH YOUR SAR 7.

CASE NUMBER \_\_\_\_\_

**NEED HELP?** (County Specific instructions w/county unurl)

Worker Name: \_\_\_\_\_ [Dist. ID here]  
 Worker Phone : (     ) \_\_\_\_\_  
 County: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip Code \_\_\_\_\_

Barcode: \_\_\_\_\_

**SPONSOR'S INSTRUCTIONS**

- You and your spouse (if living together or if your spouse has signed an affidavit of support) must complete and sign this report after the end of the Report Month listed at the top of this form and return it immediately to the non-citizen you sponsor.
- Call the county if you need help completing this form.

1. Sponsor's Name (First, Middle, Last) \_\_\_\_\_

Answer the following questions for your spouse if he/she is living with you OR signed an affidavit of support.

2. Sponsor's Spouses Name (First, Middle, Last) \_\_\_\_\_ Has sponsor's spouse signed an affidavit of  **YES**  **NO** support?

3. Do you and/or your spouse get cash aid, such as CalWORKs or SSI? If "YES", complete below.  **YES**  **NO**

CASE NAME	DATE OF BIRTH	TYPE OF CASH AID	COUNTY	STATE

4. During the Report Month did you and/or your spouse get income, money or benefits, such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment or disability insurance, interest, worker's compensation, SSI/SSP, child/spousal support, loans, grants, tax refunds, cash gifts, free housing/utilities, etc.?  **YES**  **NO**

If "YES", list WHO got income, employer's name or other source of income, GROSS amount BEFORE deductions (such as taxes, social security or other retirement deductions, garnishments, support, etc.) and actual date they got the income. Attach paystubs or other proof of earnings for the Report Month. Attach proof of any other type of income only when it starts and when it changes.

If self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

NAME	SOURCE	AMOUNT \$	AMOUNT \$	AMOUNT \$	AMOUNT \$	AMOUNT \$
		DATE RECEIVED				

5. Will there be any changes to this income in the next six months? If "YES", list below what change is expected. Attach any proof you may have such as: a letter from an employer, benefit award letter, etc.  **YES**  **NO**

Whose income will change?	What income will change?	How and when will it change?

**If both you and your spouse (if living with you) receive Cash Aid, skip to Question 11 and complete the Certification Section.**

6. Since your last report, did you or your spouse have any changes in personal and/or real property, such as: Got, bought, sold, traded, or gave away a motor vehicle, camper, boat, land or house, etc.? If "YES", please explain the type of change and the amount, if applicable.  **YES**  **NO**

7. Did you or your spouse have a checking, savings or credit union account at the end of the Report Month? If "YES", complete below.  **YES**  **NO**

<input type="checkbox"/> Credit Union	Balance On Last Day of Report Month	Whose Account?	<input type="checkbox"/> Credit Union	Balance On Last Day of Report Month	Whose Account?
<input type="checkbox"/> Checking			<input type="checkbox"/> Checking		
<input type="checkbox"/> Savings	\$		<input type="checkbox"/> Savings	\$	

COUNTY USE ONLY

WORKER INITIALS

DATE

8. Since your last report, was there a change in the number of persons who are claimed as dependents for federal income tax purposes by you or your spouse?  YES  NO  
If "YES", complete below.

NAME OF PERSON(S)	DOES PERSON LIVE WITH SPONSOR?	DATE OF CHANGE	EXPLAIN WHAT CHANGED
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	<input type="checkbox"/> YES <input type="checkbox"/> NO		

9. Since your last report, was there any change in payments made to persons who are claimed as federal tax dependents who are not living with you or your spouse?  YES  NO  
If "YES", explain what changed, list the name of the person(s), amount paid and who paid:

10. During the Report Month, did you or your spouse pay any court-ordered support?  YES  NO  
If "YES", enter the amount paid and attach receipts: \$

11. Do you or your spouse have any other information to report such as: A new address, a change in the number of noncitizens you sponsor and who will get cash aid, recent or anticipated changes in income, etc.?  YES  NO  
If "YES", explain the change and if you know if it will be temporary or permanent, and give the date of the change.

**CERTIFICATION SECTION**

- I understand that the term for sponsorship is normally an indefinite period of time.
- I understand that failure to report information or purposely giving the wrong facts for cash aid is a crime and I can be fined, go to jail or both.
- I understand that I may have to pay back any benefits that are overpaid because I did not give all of the facts or gave the wrong information.

**SPONSOR'S CERTIFICATION**

- I declare under penalty of perjury under the laws of the State of California that the information in this report is true, correct and complete.

SIGNATURE OF SPONSOR	DATE
SIGNATURE OF SPONSOR'S SPOUSE (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

**NONCITIZEN'S CERTIFICATION**

- I have reviewed this signed and completed report from my sponsor(s). I declare under penalty of perjury under the laws of the State of California that, to the best of my knowledge, the information in this report is true, correct and complete.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

**COUNTY USE ONLY SECTION**

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources	CalWORKs Sponsor/Sponsor's Spouse Income Computation	CalFresh Sponsor/Sponsor's Spouse Income Computation																																																													
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# SENIOR PARENT SEMI-ANNUAL INCOME REPORT

CASE NAME:
CASE NUMBER:
REPORT MONTH:

(Supplement to the SAR 7 - Use for unaided senior parent.)

The rules say that when a minor parent (up to age 18) gets cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

**INSTRUCTIONS:**

- Fill in this form and return it with your Semi-Annual Eligibility/Status Report (SAR 7) by the 5th day of the submission month. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete report by the 11th day of the submission month, your cash aid and cash-based Medi-Cal may be **delayed, changed** or **stopped**.
- If you have questions, ask your worker or call the county.

1. During the Report Month did your parent(s) get income, money, or benefits, such as: earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; In-Home Supportive Services (IHSS); interest or dividends from stocks, bonds, savings account; child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc?  YES  NO

If "YES", list who got the money, the source, gross amount before deductions, and actual date they got it in the Report Month. Attach paystubs or other proof of your parent's earnings in the Report Month. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses in the Report Month. Proof for any self-employment income or other income is needed only when it starts and when it changes.

WHO GOT THE INCOME	SOURCE OF INCOME	GROSS AMOUNT	\$	\$	\$	\$	\$
		ACTUAL DATE THEY GOT IT					
WHO GOT THE INCOME	SOURCE OF INCOME	GROSS AMOUNT	\$	\$	\$	\$	\$
		ACTUAL DATE THEY GOT IT					

2. Will there be any changes to this income in the next six months?  YES  NO  
 If "YES", list below what change is expected. Attach any proof they may have such as, a letter from an employer, benefit award letter, etc.

WHOSE INCOME WILL CHANGE?	WHAT INCOME WILL CHANGE?	HOW AND WHEN WILL IT CHANGE?

**CERTIFICATION**

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I received more than \$950 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to \$10,000 and/or sent to jail or prison for up to 3 years.
- I understand that the facts I report may result in my benefits being changed or stopped.
- I understand that I have the right to a State Hearing on any proposed action by the County Welfare Department.
- 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 are complete.

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

SIGNATURE OF CASH AIDED MINOR PARENT 	DATE SIGNED
--	-------------

COUNTY USE ONLY



**STATEMENT OF FACTS FOR CASH AID, CalFresh, AND MEDI-CAL/34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)**

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "CF" for CalFresh (formerly called Food Stamps), and "MC" for Medi-Cal/34-County CMSP listed to the left of each question tell you which questions are for each program.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.
- If you are asking for CalFresh and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

**CA** **CF** **MC** **1** **A. Person applying, or caretaker relative of child(ren) for whom aid is wanted.** HOME PHONE ( )

**NAME:** ( )

HOME ADDRESS (NUMBER, STREET) MAILING ADDRESS (IF DIFFERENT) DAYTIME PHONE ( )

CITY STATE ZIP CODE CITY STATE ZIP CODE

**CF** **B. Are you homeless?** If "YES": Are you temporarily staying in someone else's home?  YES  NO  
 YES  NO If "YES": Give date you began staying at this home:

**CA** **C. Have you received a pay Rent or Quit Notice?**  YES  NO

**2** **For each ADULT living in the home, give us all the facts.**

**CA (A)** ADULT'S NAME (FIRST, MIDDLE, LAST) CITIZEN/NONCITIZEN STATUS (✓)  U.S. Citizen/National  
 Noncitizen: Sponsored  YES  NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) BIRTHDATE (MONTH DAY YEAR) SOCIAL SECURITY NUMBER

SEX (✓)  M  F BLIND, DEAF OR DISABLED  YES  NO PREGNANT  YES  NO BIRTHPLACE CITY STATE COUNTRY

TYPE OF AID REQUESTED (✓)  Cash Aid  CalFresh  None  Medi-Cal  34-County CMSP

MARITAL STATUS (✓)  Married  Never Married  Separated  Divorced  Common Law  Widowed

**CA (B)** ADULT'S NAME (FIRST, MIDDLE, LAST) CITIZEN/NONCITIZEN STATUS (✓)  U.S. Citizen/National  
 Noncitizen: Sponsored  YES  NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) BIRTHDATE (MONTH DAY YEAR) SOCIAL SECURITY NUMBER

SEX (✓)  M  F BLIND, DEAF OR DISABLED  YES  NO PREGNANT  YES  NO BIRTHPLACE CITY STATE COUNTRY

TYPE OF AID REQUESTED (✓)  Cash Aid  CalFresh  None  Medi-Cal  34-County CMSP

MARITAL STATUS (✓)  Married  Never Married  Separated  Divorced  Common Law  Widowed

**CA (C)** ADULT'S NAME (FIRST, MIDDLE, LAST) CITIZEN/NONCITIZEN STATUS (✓)  U.S. Citizen/National  
 Noncitizen: Sponsored  YES  NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) BIRTHDATE (MONTH DAY YEAR) SOCIAL SECURITY NUMBER

SEX (✓)  M  F BLIND, DEAF OR DISABLED  YES  NO PREGNANT  YES  NO BIRTHPLACE CITY STATE COUNTRY

TYPE OF AID REQUESTED (✓)  Cash Aid  CalFresh  None  Medi-Cal  34-County CMSP

MARITAL STATUS (✓)  Married  Never Married  Separated  Divorced  Common Law  Widowed

COUNTY USE ONLY		
CF NON-HH/EXCLUDED MEMBER (63-402)	CF WORK/TRAINING EXEMPTIONS (63-407.21)	CF ABAWD EXEMPTIONS (63-410.3)
1. Separate HH (Purchase/prepare) (.12, .13)	a. Under 16/60 or older	1. ABAWD with CF Work/Training Exemption Code 63-407.21
2. Separate HH (Elderly/disabled) (.17)	a.(1) 16/17 not head of household; or	2. Under 18/50 or older (.321)
3. Roomer (must be listed in 13) (.211)	16/17 in school/training at least	3. Pregnant (.322)
4. Live-in attendant (.212)	1/2 time	4. Adult living in HH with dep. child (.323)
5. Other shared living quarters (.213)	b. Mentally/physically unfit for work	5. Lives in ABAWD exempt area (.33)
6. Ineligible alien (.221)	c. Mandatory participant in Welfare to Work activities	
7. Boarder (must be listed in 13) (.3)	d. Cares for child under 6 or incapacitated person	
8. SSN disqualified (.222)	e. Applicant for/recipient of UIB	
9. IPV disqualified (.223)	f. Participant in drug/alcohol program	
10. Workfare sanctioned (.225)	g. 30 hour week/min. x 30	
11. SSI/SSP recipient (.226)	h. 1/2 time student in school, training or higher education.	
12. Ineligible student (.227)		
13. Work req. disqualified (.228)		
14. Questionable Citizenship (300.51(b))		
15. Vol. quit ineligible (408.1, .2)		
16. Ineligible/disqualified ABAWD (410.4)		
17. Fleeing felon/parole or probation violator (.224)		
18. Drug felon (.229)		

**COUNTY USE ONLY**

CASE NAME

CASE NUMBER

WORKER DATE RCD

New  Restoration  
 Redetermine  Recertification

Residency Verified  
 CF ID  
 CF Aged/Disabled Verified  
 MC ID  
 MC Minor Consent: Exempt from ID, Residency, SSN, Verifs

AU  NON-AU  MFBU

CF Non-HH/Excluded Member Code:

Work Registration/Exemption Codes:  
WELFARE to WORK CF ABAWD

VERIFIED:  Blind/Deaf/Disabled  
 SSN  DED Packet  Citizen  
 Eligible Noncitizen  SAVE  
Alien Reg. # D.O.E.

COUNTY USE ONLY

3 For each CHILD living in the home, child out of the home for a short time, or child you claim as a tax dependent, give us all the facts. If you are pregnant, list child as "unborn" and give due date.

Form with 4 sections (A, B, C, D) for child information. Each section includes fields for name, status, SSN, birthdate, age, pregnancy, immunizations, disability, school enrollment, aid requested, and caregiver information. It also includes a vertical column for 'CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK BELOW)' with categories: DEATH, DISABILITY, ABSENCE, UNEMPLOYMENT. To the right of each section are checkboxes for 'AU', 'NON-AU', 'MFBU', 'MFG CHILD', and 'CF Non-HH/Excluded Member Code'.

<b>CA</b> ④ <b>List any parent(s) of the child(ren) or unborn who does not live in the home with you.</b>				<b>COUNTY USE ONLY</b>	
NAME OF PARENT	REASON THE PARENT DOES NOT LIVE IN THE HOME			<input type="checkbox"/>	Verif. on File
				<input type="checkbox"/>	MC 13
<b>CA</b> ⑤ <b>Has anyone changed citizenship/immigration status in the last 12 months?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>					
If "YES", complete below:					
NAME	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)		
<b>CA</b> ⑥ <b>A. Is a foster child living in the home?</b>				<b>YES</b>	<b>NO</b>
If "YES", who:					
<b>CA</b> <b>B. Was the child(ren) placed in your home under a dependency order from the court?</b>					
<b>CA</b> <b>C. Do you want the foster child(ren) and foster care income counted on the CalFresh case?</b>					
<b>CA</b> <b>D. Is the child(ren) enrolled in a health care plan?</b>					
<b>CF</b>				6B: <input type="checkbox"/> Request dependency order	
<b>MC</b>				6C: <input type="checkbox"/> CA and FC elig/CR chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP	
<b>CA</b> ⑦ <b>Has anyone ever used any other name (maiden, adoptive, etc.)?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>					
If "YES", complete below:					
NAME		OTHER NAME(S) USED			
NAME		OTHER NAME(S) USED			
<b>CA</b> ⑧ <b>A. Does everyone live in California?</b>				<b>YES</b>	<b>NO</b>
If "NO", explain:				Calif. Resident: <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	
<b>CA</b> <b>B. Does everyone plan to stay in California permanently?</b>					
<b>CA</b> <b>C. Does anyone own, lease or maintain a home outside California?</b>					<input type="checkbox"/> Property
<b>CA</b> <b>D. Is anyone currently getting public assistance outside California?</b>					<input type="checkbox"/> PA
If "YES", explain:					
<b>CA</b> <b>E. Is anyone planning to leave California for more than 30 days?</b>					
<b>MC</b> ⑨ <b>Are you 18 to 21 years of age and claimed as a dependent for income tax purposes?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>					
If Yes, who:				<input type="checkbox"/> Tax Dependent Letter Sent <input type="checkbox"/> CA 2.1	
<b>CA</b> ⑩ <b>A. Has anyone's cash aid or CalFresh/SNAP benefits been stopped due to:</b>				<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	
<b>CF</b> <b>non-cooperation during a quality control review, work or training sanctions or failure to meet the CalFresh Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason?</b>					
If "YES", explain below:					
NAME	WHY	WHEN	WHAT COUNTY/STATE		
<b>CA</b> <b>B. Has anyone's cash aid or CalFresh been stopped for a period of time or forever due to welfare fraud or a CalFresh Intentional Program Violation?</b>				<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	
If "YES", explain below:					
NAME	WHY	WHEN	WHAT COUNTY/STATE		
<b>CF</b> ⑪ <b>Does anyone living with you buy food and fix meals separately from others in the home?</b>				<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	Separate household eligible: <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>
If "YES", who:					
<b>CF</b> ⑫ <b>Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?</b>				<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	Separate household eligible: <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>
If "YES", who:					

**CF** **13** A. Do you pay someone else for meals and/or a room?  YES  NO  
 If "YES", complete below:

NAME OF PERSON YOU PAY	CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY
------------------------	---	----------------	-----------	----------------------

COUNTY USE ONLY		
	Household Elects	ROOMER
BOARDER	HH MEMBER	

**CA** **CF** B. Does anyone pay you for meals and/or a room?  YES  NO  
 If "YES", complete below:

NAME OF PERSON WHO PAYS YOU	CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY
-----------------------------	---	----------------	-----------	----------------------

**CF** **14** Does anyone 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

NAME	NAME OF PROGRAM	NAME	NAME OF PROGRAM
------	-----------------	------	-----------------

**CA** **CF** **MC** **15** A. Does anyone live in any of the following:  YES  NO  
 If "YES", complete below:

- Shelter, center
- Reservation for Native Americans
- Psychiatric hospital/mental institution
- Group living arrangement for the disabled/blind
- Hospital or nursing home
- Subsidized housing for the elderly
- Drug or alcohol rehabilitation center
- Board and care home
- Penal institution/correctional facility

NAME	NAME OF CENTER, SHELTER, HOSPITAL, ETC.	DATE ENTERED	DATE EXPECTED TO LEAVE
------	---	--------------	------------------------

**MC** B. Does the person who is in a hospital or nursing home have a spouse or other family member at home?  YES  NO

**CA** **16** List any child age 6-18 who does not attend school regularly and explain why he/she is not attending regularly.  No Child Age 6-18

NAME	REASON NOT ATTENDING SCHOOL REGULARLY
------	---------------------------------------

**CA** **CF** **MC** **17** A. Is anyone age 14 or older enrolled in school, college, or a training program? If "YES", complete below:  YES  NO

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

**CA** **CF** B. Complete below for anyone enrolled in college or attending a similar educational institution.

NAME	TERM (✓) CHECK STATUS <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$
MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE	DAYS ATTENDING PER WEEK	TRANSPORTATION USED	
TRANSPORTATION COST PER WEEK \$	AMOUNT PAID PER WEEK BY CAR POOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$	

**CA** **18** A. Is anyone under age 20 and pregnant or a parent?  YES  NO  
 If "YES", complete below:

NAME	AGE	CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent
------	-----	--

- SCHOOL STATUS, CHECK (✓)
- Has a High School Diploma     Has a GED     Not Attending School Regularly (explain):
- Currently Attending School Regularly     Other (explain):

**CA** B. Has anyone received a cash bonus or penalty, or help with child care, transportation, etc. from the Cal-Learn Program?  YES  NO  
 If "YES", complete below:

NAME	WHERE (COUNTY)	DATE(S) RECEIVED
------	----------------	------------------

**CA** **CF** **19** Is anyone on strike?  YES  NO  
 If "YES", complete below:

NAME OF STRIKER	NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM
NAME OF UNION	
DATE WENT ON STRIKE	MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE \$

CF Eligible Institution:  YES  NO

CA Eligible:  YES  NO

School Attendance Verified:  YES  NO

School Enrollment Verif.:  YES  NO

Date Verified:  
CF Eligible Student:  YES  NO

School Enrollment Verif.:  YES  NO  
 Date Verified:  
CF Eligible Student:  YES  NO

Expenses Verified:  YES  NO

Date Verified:

Financial Aid:  YES  NO  
 MC 210 S-E

- Referred to:
- Cal-Learn
  - CW 25
  - CW 25A
  - Referred to Welfare-to-Work

Striker Regs Apply:  
 CA     CF

**CA** **CF** **(20)** **Has anyone, including children, worked or does anyone expect to go to work, including part-time and occasional work? Check (✓) "YES" or "NO" for each item.** If "YES", complete below:

Has anyone stopped or refused work or training within the last 60 days?	YES	NO
Is anyone working or in training now?		
Does anyone expect to be working or in training in the future? If "YES", what is your anticipated start date?		

**COUNTY USE ONLY**

(A) (✓) if exempt	CF S/E Farmer
CA MC <input type="checkbox"/> CF Adult <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> CF Child	
(B) (✓) if exempt	CF S/E Farmer
CA MC <input type="checkbox"/> CF Adult <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> CF Child	
<input type="checkbox"/> Verif(s) on file for:	
<input type="checkbox"/> (A) <input type="checkbox"/> (B)	
CF: Work history last 120 days	
<input type="checkbox"/> (A) <input type="checkbox"/> (B)	
(A)	YES NO
Empl. Statement	
Good Cause Determ	
Voluntary Quit	
(A) <input type="checkbox"/> CA: 28 Days (B) <input type="checkbox"/> CA: 28 Days	
<input type="checkbox"/> CF: 60 days <input type="checkbox"/> CF: 60 days	
<input type="checkbox"/> MC: 30 days <input type="checkbox"/> MC: 30 days	
(B)	YES NO
Empl. Statement	
Good Cause Determ	
Voluntary Quit	
CA: S/E Client Chooses:	
(A) <input type="checkbox"/> Actual <input type="checkbox"/> Actual	
<input type="checkbox"/> 40% deduction <input type="checkbox"/> 40% deduction	
<input type="checkbox"/> Annualize <input type="checkbox"/> Annualize	

If self-employed: **For CalFresh:** List your business expenses on a separate sheet of paper.  
**For Cash Aid:** Check (✓) how you want your business expenses figured each month:  
 40% standard deduction  Actual business expenses  Monthly average (yearly business costs divided by 12 months). **If actual**, you must list your business expenses on a separate sheet of paper.

**(A) NAME**  
**CA**  
**CF**  
**MC**

NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____	EMPLOYER'S NAME AND ADDRESS
PAY DATE(S)	SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO
WAGES BEFORE DEDUCTIONS \$ _____ per	DATE LAST CHECK RECEIVED
REASON FOR LEAVING JOB/TRAINING	LAST DAY OF WORK/TRAINING
DATE NEXT CHECK EXPECTED	AMOUNT EXPECTED BEFORE DEDUCTIONS \$ _____
OCCUPATION	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW
AMOUNT RECEIVED \$ _____	AMOUNT EXPECTED \$ _____
WILL THIS INCOME CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO", EXPLAIN ANY KNOWN CHANGES HERE:	

**(B) NAME**  
**CA**  
**CF**  
**MC**

NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____	EMPLOYER NAME AND ADDRESS
PAY DATE(S)	SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO
WAGES BEFORE DEDUCTIONS \$ _____ per	DATE LAST CHECK RECEIVED
REASON FOR LEAVING JOB/TRAINING	LAST DAY OF WORK/TRAINING
DATE NEXT CHECK EXPECTED	AMOUNT EXPECTED BEFORE DEDUCTIONS \$ _____
OCCUPATION	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW
AMOUNT RECEIVED \$ _____	AMOUNT EXPECTED \$ _____
WILL THIS INCOME CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO", EXPLAIN ANY KNOWN CHANGES HERE:	

**CA** **CF** **MC** **(21) A.** **Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job?**  YES  NO  
 If "YES", complete below and (✓) if for work or training.

WHO GETS CARE	WHO PAYS	WHO GIVES CARE	<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	AMOUNT PAID/HOW OFTEN \$ _____ EVERY
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	AMOUNT PAID/HOW OFTEN \$ _____ EVERY

**CA** **CF** **MC** **B.** **Does anyone else pay all or part of your child care costs?**  YES  NO  
 Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:

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

**CF** **MC** **(22)** **Does anyone pay child or spousal support?**  YES  NO  
 If "YES", complete below:

WHO PAYS	FOR WHOM	AMOUNT PER MONTH \$ _____
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**CA** **CF** **MC** **(23)** **Has anyone, including children, applied for or received unemployment or disability insurance benefits in the last 12 months OR expect to receive these benefits in the future?**  YES  NO  
 If "YES", complete below:

NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED

**CA** **(24)** **Has anyone received a Diversion cash payment or non-cash services from any county or other state?**  YES  NO  
 If "YES", complete below:

NAME	COUNTY/STATE	AMOUNT RECEIVED \$ _____	LIST SERVICES RECEIVED	ESTIMATED VALUE OF SERVICES \$ _____	DATE RECEIVED
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**Child Care Informing:**

Trustline Informing (CCP 2)

Health & Safety Certification (CCP 5)

Dependent Care Verified

DEP. CARE ELIGIBLE	YES	NO
CF		
MC		

Is there another person in household who could provide care?  YES  NO

If "YES", who: \_\_\_\_\_

Court Order on File  YES  NO  
 Amount Ordered: \$ \_\_\_\_\_

CA 25 Has any parent living in the home worked or been in training in the past 24 months? YES NO

CF If "YES", complete below:
Include all work done in and outside the United States (U.S.).
Include work done in exchange for something besides money, such as rent, food, utilities or anything else.
Include any paid jobs the county helped you to get.
Begin with each person's most recent job or training.

COUNTY USE ONLY

PE/UIB Requirements
Earnings from month prior to month of application

App Date:
Earnings from
to
MO/YR 25 A 25 B

A. NAME IS HE/SHE A NATIVE AMERICAN? YES NO
IF "YES", LIST TRIBE:

Table with 6 columns: Name and Address of Employer or Training Program, When Employed (MO DAY YR), Amount Paid, Name and Address of Employer or Training Program, When Employed (MO DAY YR), Amount Paid. Includes checkboxes for Work/Training and payment frequency.

B. NAME IS HE/SHE A NATIVE AMERICAN? YES NO
IF "YES", LIST TRIBE:

Table with 6 columns: Name and Address of Employer or Training Program, When Employed (MO DAY YR), Amount Paid, Name and Address of Employer or Training Program, When Employed (MO DAY YR), Amount Paid. Includes checkboxes for Work/Training and payment frequency.

CF 26 Are all CalFresh household members citizens of the United States (U.S.)? YES NO
If "NO", complete below for each CalFresh household member who is not a citizen of the U.S.

Table with 3 columns: Name of each noncitizen, A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S., B. While living in the U.S., in how many of the years reported in Column A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S., C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S?

TOTAL \$ \$
25 A B
Tribal JOBS Referral
UIB Verif(s) on file
Must apply for UIB

CA 27 Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service? YES NO
CF MC If "YES", complete below:

Table with 6 columns: NAME, U.S. CITIZEN, STATUS, HONORABLE DISCHARGE, BRANCH OF SERVICE, DATE OF SERVICE. Includes checkboxes for YES/NO and status options.

Currently Receiving/Got/ or UIB eligible in last 12 months
UIB Ineligible Reason:

26 CF: 40 Quarters Verif.

27 CW 5
CF: Noncitizen's Honorable Discharge Verif. YES NO

COUNTY USE ONLY

Table with 3 columns: PRINCIPAL EARNER (PE) \*, DATE OF APPLICATION, QUARTER OF APPLICATION

\*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

**CA (28) A. Does anyone, including children, get or expect to get money from any source listed below?**

Check (✓) "YES" or "NO" for each item.

	YES	NO		YES	NO
Work Study, Welfare-to-Work, or other program			VA (Veterans) educational related income		
Other training allowance			VA Aid & Attendance		
Educational grants, loans and scholarships			Social Security disability or supplemental security income/state supplementary payment (SSI/SSP)		
CalWORKs/Cash aid from another state			VA disability		
Refugee (RCA) Assistance			Railroad disability		
Cash Assistance Program for Immigrants (CAPI)			Other disability income from a federal, state, or local governmental agency		
GA/GR (General Assistance/Relief)			Other non-government disability or sick leave		
Workers Compensation			Social Security retirement or survivors		
Child/spousal support or money for medical bills or premiums			Railroad retirement		
Strike benefits			Other retirement income from a federal, state, or local governmental agency		
Loans, gifts, contributions			Other non-government retirement income		
Legal or insurance settlements/ court actions pending			Per capita payments		
Sales of notes, contracts, trust deeds, promissary notes			Winnings (gambling/lottery/bingo, prizes, etc.)		
Military allotment or pension			Other (Explain)		

**COUNTY USE ONLY**

- Casualty Unit Notified
- CWC 6041
- DHS 6155
- Verif(s) on File  
Explain Anticip. Income
- Workers Comp:
  - Temporary
  - Permanent

If "YES", complete below:

NAME	SOURCE	(AMOUNT RECEIVED BEFORE DEDUCTIONS)	WHEN	HOW OFTEN
		\$		
		\$		

(✓) if exempt

CA	CF	MC

**CA B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise?**

YES  NO

If "YES", complete below:

NAME	WHAT	AMOUNT \$	WHEN

**CA (29) Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?**

YES  NO

If "YES", complete below and check (✓) if free or in exchange for work:

ITEM RECEIVED	Free	For Work	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM
Housing or rent				\$	
Utilities				\$	
Food				\$	
Clothing				\$	

In-Kind Income:

Verif. on file:  YES  NO

Partial	Full	Earned	Unearned

**CA (30) A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?**

YES  NO

If "YES", complete below. Include land and/or buildings in which the title is shared.

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✓)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					\$	\$
	RENTAL PROPERTY						
OTHER (EXPLAIN):							
	LIVE IN IT					\$	\$
	RENTAL PROPERTY						
OTHER (EXPLAIN):							

Home Exempt  YES  NO

Other Real Property

Market Value \$

Amount Owed \$

Net Value \$

Lien Applicable  YES  NO

Listed for sale  YES  NO

Home Exempt  YES  NO

Other Real Property

Market Value \$

Amount Owed \$

Net Value \$

Lien Applicable  YES  NO

Listed for sale  YES  NO

**CA B. Does anyone own a house that is not lived in now that he/she hopes to return to someday?**

YES  NO

If "YES", complete below:

OWNER OF PROPERTY	PROPERTY ADDRESS	EXPECTED DATE OF RETURN (IF KNOWN)

Total countable property: Page 7 (List totals on page 9)

CA \$

CF \$

MC \$

**CA** **CF** **MC** **31) A. Does anyone, including children, have any of the following personal or business-related resources?** Check (✓) each item either "YES" or "NO".  
 Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

**COUNTY USE ONLY**

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Trust funds (whether or not available)		
Uncashed checks (on hand or elsewhere)			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Savings accounts - children's and adult's			IRA or Keogh plans, etc.		
Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)		
Credit union accounts			Employee deferred compensation plans		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance or annuity		
Oil, mining, or mineral rights			Life estate interest in any property		
Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Long term care insurance		
Income tax refund			EBT cash balance from a previous month		
			Other (explain)		

- Trust Fund/Not Court Ordered
- Court Petitioned Date \_\_\_\_\_
- Resource Verified: Explain how: \_\_\_\_\_
- Total Value = \$ \_\_\_\_\_
- Burial Reserve or Trust (MCO) Amount Owed \$ \_\_\_\_\_
  - Revocable
  - Irrevocable
  - Designated Fund and Current Value \$ \_\_\_\_\_
- CA Restricted Account

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS-RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$

Check (✓) if exempt		
CA	CF	MC

**CA** **CF** **MC** **B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?**  YES  NO  
 If "YES", complete below:

NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN	BUSINESS-RELATED
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO

**MC** **32) Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services?**  YES  NO  
 If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
\$			
\$			

- Verified:  YES  NO
- Lien Applicable:  YES  NO
- Security Agreement:  YES  NO
- MC 174 completed and sent:  YES  NO

**MC** **33) A. Does anyone own any personal property, such as:**  YES  NO

- Non-motorboats, camper shells, non-motor trailers.
- Guns; tools; or sporting equipment, etc.
- Pets or livestock for personal use.
- Jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms. List jewelry worth more than \$100 and household goods or personal items worth more than \$500 per item.

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$

- Owned Jointly
- Owned Separately
- Personal Property \$500 + for Pickle Program
- Insignificant Value for 1931(b)
- Listed for sale (Specify): \_\_\_\_\_

**MC** **B. Does anyone have any business property, including tools, inventory and materials, business equipment, livestock, etc.?**  YES  NO  
 Include any property that is shared or held jointly with any other person(s). If "YES", complete below:

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$

Total Countable Property: Page 8  
 (List totals on Page 9)  
 CA \$ \_\_\_\_\_  
 CF \$ \_\_\_\_\_  
 MC \$ \_\_\_\_\_  
 Listed for sale (Specify): \_\_\_\_\_

CA MC CF **34** Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else? (List any property sold or traded within the last 12 months for cash aid, 3 months for CalFresh, and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when:  YES  NO

**COUNTY USE ONLY**

Transfer of Assets:  
 CA in last 12 months  
 CF in last 3 months  
 Medi-Cal in last 30 months

LTC ONLY  
 Adequate Consideration  
 Spenddown

Total Nonexempt Property \$

CA MC **35** Does anyone own, have the use of or have their name on the registration of any motor vehicle, such as: automobile, motorcycle, snowmobile, recreational vehicle, motorboat, etc., even if not running? If "YES", complete below. Look at your registration to get facts for each vehicle:  YES  NO

Compute Vehicle Valuation in Section Below:

Verifications viewed  
 Leased vehicle:  
 (1)  (2)  (3)  
 Pickle Program:  
 Use Pickle Handbook (Reference Section 9)

	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
OWNER OF VEHICLE						
NAME OF PERSON WHO USES VEHICLE						
YEAR/MAKE/MODEL						
LICENSE NUMBER						
ESTIMATED VALUE	\$		\$		\$	
BALANCE OWED	\$		\$		\$	
LICENSED	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
LEASED	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
HOW DO YOU USE THE VEHICLE? Check (✓) each item "YES" OR "NO."						
	YES	NO	YES	NO	YES	NO
As a Home						
To go to work or training or for job search						
For self-employment, self-support, or business use						
Needed for disabled household member						
To get household's fuel or water						
For recreational use only						

Vehicle Value  
 (Enter Date of blue book issue or other documentation)

(1) Date: \_\_\_\_\_ \$ \_\_\_\_\_  
 (2) Date: \_\_\_\_\_ \$ \_\_\_\_\_  
 (3) Date: \_\_\_\_\_ \$ \_\_\_\_\_

**COUNTY USE ONLY - VEHICLES**

**(C) Fair Market Values-CA**

CASH AID	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
<b>(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)</b>	<input type="checkbox"/> YES (Exclude)	<input type="checkbox"/> NO Go to (B).	<input type="checkbox"/> YES (Exclude)	<input type="checkbox"/> NO Go to (B).	<input type="checkbox"/> YES (Exclude)	<input type="checkbox"/> NO Go to (B).
<b>(B) (1) Equity: exempt one vehicle, regardless of use. (63-501.523) [If "YES", go to (C). If "NO", go to (B)(2).]</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>(2) Is other vehicle(s) used for job search, employment or training?</b>	<input type="checkbox"/> YES Go to (C). Use Excess Value.	<input type="checkbox"/> NO Go to (C) and (D). Use Greater Value.	<input type="checkbox"/> YES Go to (C). Use Excess Value.	<input type="checkbox"/> NO Go to (C) and (D). Use Greater Value.	<input type="checkbox"/> YES Go to (C). Use Excess Value.	<input type="checkbox"/> NO Go to (C) and (D). Use Greater Value.

FMV				
Minus	Minus	Minus	Minus	
	\$4,650	\$4,650	\$4,650	
Excess Value				

**(D) Equity Values-CA**

FMV			
Minus Encumbrance			
Equity Value			

	MEDI-CAL	
	(1)	(2)
DMV/YR/Class Code	_____	_____
Vehicle Market Value	\$ _____	\$ _____
Less Encumbrances	\$ _____	\$ _____
Net Value	\$ _____	\$ _____
Exempt	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

TOTALS: VEHICLE CA  
 Excess Value \$ \_\_\_\_\_  
 Equity Value \$ \_\_\_\_\_

Grand Total Countable Property  
 (List totals from pages 7, 8, and 9)

Page	CA	CF	MC
(9)	\$ _____	\$ _____	\$ _____
(8)	\$ _____	\$ _____	\$ _____
(7)	\$ _____	\$ _____	\$ _____
Total	\$ _____	\$ _____	\$ _____

**Pickle Program** (Ref. Sec. 9 in Pickle Handbook):

	(1)	(2)	(3)
Is vehicle used:	Exempt	Yes	No
As a home			
For self-employment			
To Go to Work or Medical Appointment			

**CA** **CF** **(36) A. Does anyone have any housing costs?**  **YES**  **NO**  
 If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	\$	\$	\$	
House (mortgage) payment	\$	\$	\$	
Property taxes (if not in house payment)	\$	\$	\$	
Insurance (if not in house payment)	\$	\$	\$	
Other (explain)	\$	\$	\$	

**COUNTY USE ONLY**

Housing verified:  YES  NO  
 Total housing: \$ \_\_\_\_\_  
 Shared housing:  YES  NO

**CA** **CF** **B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc.**  **YES**  **NO**  
 If "YES", complete below:

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		\$	
		\$	

**CF** **(37) A. 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)	

Utilities verified:  YES  NO  
 Verification not required

**CF** **B. 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

Utility allowance  
 SUA  
 LUA  
 TUA  
 None allowed

**CF** **(38) You can authorize someone else in your household or someone outside your household to use your CalFresh benefits to buy food for you. If you would like to authorize someone, complete below:**

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		( )

CalFresh I.D. Issued

**CA MC 39** Did anyone get medical/pregnancy treatment this month or in the three months before this month?  YES  NO  
If "YES", complete below:

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDICAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

**COUNTY USE ONLY**

Retroactive Application  
 Retro Only  
 Retro and Cont.  
 MC 210A

**CA CF MC 40** Does anyone have MEDICARE coverage?  YES  NO  
If "YES", complete below:

PERSON COVERED	MEDICARE CLAIM NUMBER	FOR	HOW MONTHLY PREMIUM IS PAID		
			DEDUCTED FROM CHECK	OUT OF POCKET	OTHER
		Part A			
		Part B			
		Part A			
		Part B			

MEDICARE referral

CF:  DFA 285-C  
 Gross Premium \$ \_\_\_\_\_  
 QMB  
 SLMB/QI  
 QDWI

**CA MC 41** Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans, such as Kaiser, Blue Cross, CHAMPUS, etc.?  YES  NO  
If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			\$	
			\$	

State Certified LTC Policy:  YES  NO  
 DHS 6155  
 Benefits Paid Out \$ \_\_\_\_\_

**CA MC 42** Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for?  YES  NO  
If "YES", complete below:

INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID
		\$	
		\$	

DHS 6155

**CA MC 43** Is anyone's health insurance expected to end or has it ended within the last 60 days?  YES  NO  
If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			\$	
			\$	

DHS 6155

**CA MC 44** Does anyone 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:

NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

Third Party Liability

**CA CF 45 A.** Does anyone have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item "YES" or "NO":

	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)					

Verified:  YES  NO  
 Special Need:  YES  NO  
 Amount: \$ \_\_\_\_\_

**CA CF MC B.** Is there a child or disabled person in the household who needs care from another household member?  YES  NO  
If "YES", explain:

**CA MC C.** Is anyone a disabled person who is working and who has medical expenses (wheelchair, etc.), which are needed for the person to be able to work?  YES  NO  
If "YES", complete below:

NAME OF PERSON	TYPE OF EXPENSE	AMOUNT
		\$
		\$

Receipts  YES  NO  
 MC 272  MC 273  
 IRWE (QMB and SGA)  
 CF:  DFA 285-C

**CA CF D.** Is anyone getting In-Home Supportive Services (IHSS)?  YES  NO  
If "YES", who gets service? \_\_\_\_\_ How much do you pay each month? \$ \_\_\_\_\_

<p>CA (46) Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire, or flood? If "YES", explain below.</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<b>COUNTY USE ONLY</b>		
	Special Need Verified	YES NO	
	Eligible for Special Need	YES NO	
<p>CA (47) Are you or any member of the household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? If "YES", give name of the person:</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
<p>CA (48) Have you or any member of your household been found by a court of law to be in violation of probation or parole? If "YES", give name of the person:</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
<p>CA (49) Have you or any member of your household been convicted of a drug-related felony? If No, go to question 50.</p> <p>If Yes, Name: _____ Date convicted: _____ .</p> <p>Was the conviction for any of the following:</p> <ul style="list-style-type: none"> <li>• 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? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>• Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> </ul> <p><b>Have you or any member of your household:</b></p> <p>a) Completed a government recognized drug treatment program? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>b) Participated in a government recognized drug treatment program? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>c) Enrolled in a government recognized drug treatment program? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>d) Been placed on a waiting list for a government recognized drug treatment program? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>e) Stopped the use of controlled substances and have evidence that you have stopped? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>If Yes, please explain: _____</p>	<p>CF convictions after 8/22/96 CW convictions after 1/1/98</p> <p>Qualifying Drug Felon? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Meets felony conditions of eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>CA (50) The following services are available. Your answers to these questions will not affect your eligibility. Check (✓) each item "YES" or "NO."</p> <p>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.</p> <ul style="list-style-type: none"> <li>• Do you want more information about CHDP Services? .....</li> <li>• Do you want CHDP medical services?.....</li> <li>• Do you want CHDP dental services? .....</li> <li>• Do you need help making appointments or with transportation to CHDP services? .....</li> </ul> <p>B. Do you want more information about immunization services?.....</p> <p>C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help? .....</p> <p>D. Are you breastfeeding a child? .....</p> <p>If "YES", have you given birth within the last 12 months?.....</p> <p>If you checked "YES" to (49) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).</p> <p>E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.</p>	<b>YES</b>	<b>NO</b>	<p><input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____</p> <p><input type="checkbox"/> CHDP Referral</p> <p><input type="checkbox"/> Social Services Referral (MCO)</p> <p><input type="checkbox"/> Referred for Immuniz.</p> <p><input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5</p> <p><input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum</p> <p><input type="checkbox"/> WIC referral</p> <p><input type="checkbox"/> Family Planning Information Given</p> <p><input type="checkbox"/> Referred Date:</p>

**CERTIFICATION**

**I understand that:**

- 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, school attendance, etc. And for cash aid and CalFresh, records will be matched with law enforcement agencies for arrest warrants.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, CalFresh, 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 U.S. Citizenship and Immigration Services (USCIS) (Formerly INS) to verify immigration status and the facts the county gets from USCIS may affect my eligibility for cash aid, CalFresh, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident noncitizen (LPR), (b) an amnesty alien with a valid and current I-688, or (c) a noncitizen permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the USCIS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The CalFresh household, any adult member of a CalFresh household (even if he/she moves out), the sponsor of a noncitizen 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 to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime or has been found by a court of law to be in violation of their probation or parole cannot get cash aid or CalFresh.
- Any household member who has been convicted after August 22, 1996 of a drug-related felony for possession, use, manufacturing, sale, distribution of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities, cannot receive CalFresh.
- For cash aid, the county will require that I and certain household members be fingerprint and photo imaged. My benefits may be denied or stopped if I do not cooperate.

**I also understand that:**

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

**For cash aid:**

- If I on purpose do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years. And 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; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
  - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
  - For conviction of felony thefts to get aid: 2 years for theft of amounts under \$2000; 5 years for amounts of \$2000 through \$4999.99; and forever for amounts of \$5000 or more.
  - 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 false proof 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: forever.

**For CalFresh:**

- If on purpose I do not follow CalFresh rules, my CalFresh will 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 CalFresh benefits for firearms, ammunition, or explosives, my CalFresh benefits can be stopped forever for the first violation.
  - I traded or sold CalFresh benefits for controlled substances, my CalFresh benefits can be stopped for 24 months for the first violation and forever for the second.
  - I traded or sold CalFresh benefits that were worth \$500 or more, my CalFresh benefits can be stopped forever.
  - I filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, my CalFresh benefits can be stopped for 10 years.

**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, MEDI-CAL APPLICANT, ADULT CALFRESH HOUSEHOLD MEMBER OR CALFRESH AUTHORIZED REPRESENTATIVE)			DATE
SIGNATURE (SPOUSE, REGISTERED DOMESTIC PARTNER, OR OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY																		
ELIGIBILITY FACTORS REVIEWED						ELIGIBILITY FACTORS REVIEWED						CalFresh TESTS						
		CA		CF		MC				CA		CF		MC				
		YES	NO	YES	NO	YES	NO			YES	NO	YES	NO	YES	NO	YES NO NA		
Residency								Property/Resources—Within limits								Categorically Eligible		
Deprivation								Work participation								Gross Income Test Household Size		
Age								Employment & Training (E & T)								Gross Monthly Income \$		
Immunizations								ABAWDs								Gross Income Eligible		
Citizen/Eligible noncitizen								CFAP								Separate HH Income Test Household Size		
School enrollment								Sponsored noncitizen Federal participation established (If "NO", explain)								Gross Monthly Income \$		
Pregnancy verif./ WIC Referral	/	/			/	/		Referred for Health Care Options (HCO) Presentation								Eligible for Separate HH Status		
SSN																Aged/Disabled		
Income—Applicant/Recipient test(s)																DFA 285-C		
SFIS																Gross Income less than \$150 and cash on hand, checking and savings accounts of \$100 or less?		
TANF Time Limits																Combined gross income and liquid resources less than the combined rent/mortgage and appropriate utility allowance?		
CalWORKs Time Limits																Migrant/seasonal farm worker household with liquid resources not exceeding \$100?		

**COMMENTS**

AU Size:	Non-AU Size:	AU/MFBU Size:
<input type="checkbox"/> INELIGIBLE (REASON)		
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> REDETERMINATION	<input type="checkbox"/> DIVERSION <input type="checkbox"/> EXEMPT MAP	AUTHORIZATION DATE
ELIGIBILITY CONDITIONS MET (DATE):		EFFECTIVE DATE
WORKER'S SIGNATURE		DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)		DATE

CF:	HH Size:
<input type="checkbox"/> INELIGIBLE (REASON)	
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> RECERTIFICATION	AUTHORIZATION DATE
WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)	DATE



## RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

### For the Cash Aid and CalFresh Programs, and/or Medi-Cal/34-County Medical Services Program (CMSP)

These pages give you your rights and responsibilities and other important information. The county needs your facts to see if you are eligible for cash aid, CalFresh benefits, and/or Medi-Cal/34-County CMSP and to figure how much you will get if you are eligible. If you need more information or have questions, ask your worker.

Cash Aid includes California Work Opportunity and Responsibility to Kids (CalWORKs) and Refugee Cash Assistance (RCA).

Medi-Cal/34-County CMSP includes Full Medi-Cal/34-County CMSP benefits and Restricted Medi-Cal/34-County CMSP emergency and pregnancy related care only.

### YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel you have been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

State Civil Rights Bureau  
744 P Street, MS 8-16-70  
P.O. Box 944243  
Sacramento, CA 94244-2430

or by calling toll free 1-866-741-6241 or for the hearing impaired TDD 1-800-688-4486.

2. To get help applying for or continuing to receive cash aid, benefits and services if you have a disability. If you need help because of a disability, tell the county.
3. To ask for help to complete your application or any other cash aid, CalFresh, or Medi-Cal/34-County CMSP form.
4. To ask for an interpreter and to have forms and notices translated if you don't speak or read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have your eligibility determined within 45 days for cash aid and Medi-Cal/34-County CMSP (or 90 days for Medi-Cal if a determination of disability is required) and within 30 days for CalFresh benefits.
7. To discuss your case with the county and to review your case yourself when you request to do so.
8. To be told the rules for getting cash aid right away. If we think you might be eligible, you will get an interview within one day.
9. To be told the rules for getting CalFresh benefits right away. If we think you might be eligible to get them right away, you will get an interview immediately and get CalFresh benefits within three days.
10. To get Medi-Cal/34-County CMSP as soon as possible if you have a medical emergency or are pregnant, if eligible.
11. To continue getting cash aid and Medi-Cal benefits without a break if you move from one county to another if you stay eligible.
12. To be told the rules for retroactive Medi-Cal eligibility.
13. To lower any current Share of Cost you may have by giving the county past unpaid medical bills you still owe, when you apply for Medi-Cal.
14. To choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when eligible for Medi-Cal.
15. To ask to have your Medi-Cal Benefits Identification Card (BIC), or EBT card replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible.
16. To ask for extra money if your income drops or stops (cash aid only).
17. To ask for payments for clothing, housing or essential household items which are lost, damaged or otherwise unavailable due to sudden and unusual circumstances (cash aid only).
18. To ask for payments for ongoing special needs like a special diet, transportation for ongoing medical care, special laundry service, telephone for the hard of hearing, high utility bills, etc. (cash aid only).
19. To be notified in writing when your application is approved, denied, or when your benefits change or stop.
20. To have your records kept confidential by the county and state, unless you are getting cash aid or CalFresh benefits and there is a felony arrest warrant issued for you, or as otherwise provided by law.
21. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
22. To ask for a State Hearing within 90 days of the county's action for cash aid, CalFresh and Medi-Cal.
23. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 21 above.
24. To be represented at a State Hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.
25. To have reasonable access to a location where you can withdraw your cash benefits with minimal or no costs.
26. To get a brochure that will tell you how to use your EBT card and how to get your cash benefits at minimal or no costs.
27. To get a list of surcharge-free ATMs and stores where you can get cash back at no cost when you make a purchase with your EBT card. You can get a list of these locations from your county worker or at [www.ebt.ca.gov](http://www.ebt.ca.gov).

## YOUR RESPONSIBILITIES

### Citizenship/Immigration Status

To sign under penalty of perjury that each person applying for cash aid and CalFresh benefits is a U.S. citizen, U.S. national, or has lawful immigration status. We will check the immigration status information with the U.S. Citizenship and Immigration Services (USCIS) to make sure the person is eligible. For CalFresh, if there are people in your home who are not applying for CalFresh benefits, you do not have to provide their citizenship or immigration status.

If you want Medi-Cal/34-County CMSP, you must provide a declaration of citizenship/immigration status under penalty of perjury. If you say you are a noncitizen with lawful permanent residence (LPR) in the U.S., an amnesty alien with a valid and current I-688 or a noncitizen permanently residing under color of law (PRUCOL), your immigration status will be checked with the USCIS. The information the USCIS gets to verify the immigration status of the applicant can only be used to determine Medi-Cal/34-County CMSP eligibility, and cannot be used for immigration enforcement, unless you are committing fraud.

### Fingerprint/Photo Imaging

All eligible adult household members for cash aid, and any adult applying for a child-only grant, must be fingerprint/photo imaged. If you are required to meet this rule but do not get fingerprint/photo imaged, the entire household will not get cash aid benefits. (Manual of Policies and Procedures (MPP) Section 40-105.3.)

The fingerprint/photo images are confidential. We can only use them to prevent fraud or to bring a criminal case against you for welfare fraud.

### Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for cash aid, CalFresh and Medi-Cal/34-County CMSP may result in repayment of benefits and/or criminal or civil action.

**Cash Aid and CalFresh Benefits:** You must give us the SSN for each applicant or recipient of cash aid and/or CalFresh. If you refuse to give us either a SSN or proof of application for a SSN, you will not be able to get cash aid or CalFresh benefits. For CalFresh, if there are people in your home who are not applying for CalFresh benefits, you do not have to provide their SSN. For cash aid, you must give proof of application for a SSN within 30 days of application for cash aid and give the SSN to the county when you get it. (MPP Section 40-105.2).

Each applicant for Medi-Cal/34-County CMSP, who says he/she is a U.S. citizen, a U.S. national, LPR in the U.S., an amnesty alien with a valid and current I-688, or PRUCOL, will be disqualified from getting Medi-Cal if he/she refuses to give either a SSN or proof of application for a SSN. Any noncitizen who does not have a SSN and who is not an amnesty alien with a valid and current I-688 or a LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

### Verification(s)

To give proof to support your eligibility. If you can't get proof, we will help you get it. You may need to sign a release for third party information or sign a sworn statement. (MPP Sections 40-105.1; 40-157.212; 40-157.213)

### Cooperation

To cooperate with county, state and federal staff. For cash aid, a county worker can come to your home at an arranged time to check out your facts, including seeing each family member. You may not get benefits or your benefits may be stopped if you don't cooperate.

## CASH AID AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, Social Security or Medicare, etc.

### Child/Spousal and Medical Support

To cooperate with the county and the Local Child Support Agency to:

- identify and locate any absent parent in your case;
- tell the county or the Local Child Support Agency anytime you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- get medical support money from any absent parent and, if you get cash aid, get child support money;
- give the Local Child Support Agency any medical support money and, any child/spousal support money you get;
- tell the county about medical coverage or money for medical services paid by the absent parent.

Your cash aid will be lowered if you fail to cooperate without a good reason. (MPP Sections 40-157.212; 40-157.213).

## MEDI-CAL

### Benefits Identification Card (BIC)

- To sign your BIC when you get it and to use it only to get necessary health care services.
- **To never throw your BIC away** (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
- To take the BIC to your medical provider when you or a family member is sick or has an appointment.
- To take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.

### Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance you or a family member have.
- To keep any health insurance available to you and your family at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans you have before using Medi-Cal/34-County CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.
- To enroll and stay enrolled in an employment-related group health plan when Medi-Cal approves payment of plan premiums by the State of California.

## YOUR REPORTING RESPONSIBILITIES

You must report certain information to the county. If you're not sure how to report, what to report, or what proof we need, ask your worker. If you get CalFresh benefits, your worker will tell you if you are a semi-annual or change reporting household. If you get Medi-Cal/34-County CMSP, the county will tell you when you must report. (MPP Section 40-181).

### HOW YOU MUST REPORT

**For Cash Aid and CalFresh Semi-Annual Reporting**, in addition to your annual SAWS 2 you must turn in a Semi-Annual Eligibility Report (SAR 7) by the fifth day of the month following your report month and report all required changes to the county within 10 days.

**For CalFresh Change Reporting**, you must report all changes within 10 days:

- by mail, telephone, or in person at the county CalFresh office; OR
- on the SAR 3 or AR 3; OR
- on a DFA 377.5, CalFresh Household Change Report

**For Medi-Cal**, you must report all changes within 10 days AND turn in a complete Status Report by the 5th of the month when the county sends or gives it to you.

### WHEN YOU MUST REPORT

#### For Cash Aid and CalFresh Semi-Annual Reporting

Semi-Annual Reporting (SAR) rules say that you must report certain things two times each year. The first report will be your application or redetermination/recertification (RD/RC) on your statement of facts (SAWS 2) form. The second report will be the Semi-Annual Eligibility Report (SAR 7). The SAR 7 report is always due by the 5th day of the sixth month following your application or annual RD/RC and will be considered late if not received by the 11th day of the month. If your SAR 7 is late you will have to pay back any cash aid or CalFresh that you were not supposed to get. You will have to report gross income, as well as any changes in your gross income that you are sure will happen in the next six months, changes in the number of people in your household and information about any new household member, and any property bought or sold by people in your household. The report month will be on the top of the SAR 7 form. If you do not turn in a completed SAR 7 by the end of the first working day of the month after the month your report is due, your household's benefits will be stopped. If you turn in your complete SAR 7 at any time in the month following the month your SAR 7 is due, your household's benefits will be started again from the date you turn it in, if you are still eligible.

What you must report on the Semi-Annual Report (SAR 7):

1. **Earned Income:** All gross earned income you or anyone in your household got in the report month. This includes wages; tips; vacation pay; cash bonuses; In-Home Supportive Services (IHSS); money from self-employment or from a training program; also any income in kind you or anyone in your household got in exchange for work, such as free rent, clothing or food.

2. **Unearned or Disability Based Income:** All other income you or anyone in your household got in the report month. This includes 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, worker's compensation, state disability indemnity (SDI), veterans or railroad retirement, or other private or government disability or retirement; rental income and rental assistance; free housing/utilities/clothing/food; or any other type of money you or anyone in your household got. You must also report on your SAR 7 any changes in income that you are sure will happen during the next six months. This includes earned, unearned and disability based income changes.
3. **Property:** Any property including: motor vehicles; bank accounts; savings bonds; insurance policies; a home or land; trust; EBT cash balance, etc. that you or anyone in your household has gotten since you last reported and still has, whether it was bought, gotten through a trade or as a gift. The county will use this information to decide if your household exceeds the property limit. You must also report if you or anyone sold, traded or gave away any property since you last reported.
4. **If You Move or Someone Moves Into or Out of Your Home:** Anyone (including newborns) who moved into your home since you last reported and is still there. You must also report anyone who moved out of your home or who has died since you last reported.
5. **Convicted Drug Felons, Fleeing Felons and Probation/ Parole Violators:** The name of anyone in your household who is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime. The name of anyone in your household who has been found by a court of law to be in violation of probation or parole. You must also report any household member who has been convicted of a drug felony for possession, use, manufacturing, sale, or distribution, of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in these activities. For CalFresh you must report felonies that happened since August 22, 1996 and for cash aid list convictions that happened after January 1, 1998.
6. **Reduced Hours of Work:** If you are between 19 and 50 and you are not caring for minor children, you must report when your hours of work drop below 20 hours a week or 80 hours a month. You must also report if you know your work hours will drop below these limits during the next six months.

#### For Medi-Cal/34-County CMSP, you must report when:

1. Anyone enters or leaves a nursing home or long term care facility.
2. Anyone applies for disability benefits, such as SSI/SSP, Social Security, Veterans, or Railroad Retirement.
3. Anyone gets health care services that result from an accident or injury due to someone else's action or failure to act.

## YOUR REPORTING RESPONSIBILITIES (CONTINUED)

### For Non-Assistance CalFresh Semi-Annual Reporting

If you only get CalFresh benefits you must report when:

1. Anytime that your household's total gross monthly income is more than the Income Reporting Threshold (IRT) for your household size. Your IRT is 130% of the Federal Poverty level for your household size. The county will tell you your IRT.
2. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

### For CalWORKs you must report certain changes at other times:

In certain circumstances you will be required to report things (within ten days of the change) even if it is not your "report month" such as:

1. Anytime that your family's combined gross income (both earned and unearned) is more than the Income Reporting Threshold (IRT) for your family. The county will tell you your IRT. If your family only gets unearned income, you will only be required to report income on your Semi-Annual Eligibility Report (SAR 7) and your annual RD/RC (SAWS 2).
2. Anytime that someone in your household is convicted of a drug related felony, becomes a fleeing felon or is found by a court to be in violation of probation or parole.
3. Anytime you move you must report your address change so that the county will know where to send your SAR 7 and other notices.

### Reporting information voluntarily for CalWORKs and CalFresh Semi-Annual Reporting:

You may also report other information voluntarily even when it is not your "report month." Reporting information voluntarily may cause your household's benefits to go up. If the information reported causes your benefits to go up, the county will take action within ten days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the county will take action to increase benefits the first of the month after you provide verification.

Some examples of voluntary reporting that may cause your benefits to go up include:

- Your income stops or drops.
- Someone who has little or no income moves into your home (including a newborn).
- Someone who has income moves out of your home.
- You believe that you or someone in your household is eligible for a CalWORKs Special Needs payment, such as pregnancy special needs or a qualifying special diet.

### Additional examples for CalFresh only:

- A household member begins to pay court ordered child support for a child not living in the home.
- A household member is 60 or older.
- Any member who is disabled or 60 years of age or older has changes in or new medical expenses (if verified your CalFresh can be refigured).

At anytime you can ask the county to discontinue your entire case or any individual person who has left the home or is not required to be in the assistance unit. You can also ask the county to discontinue certain benefits, such as: Medi-Cal or CalFresh. Receiving Medi-Cal/or CalFresh only will not count against your cash aid time limits.

### Additional Information for CalFresh Only Households

If you receive only CalFresh benefits and you voluntarily report that someone has moved into or out of your home, the county will act on that change even if it results in a decrease to your CalFresh benefits.

### Other changes for Semi-Annual Reporting:

There are other changes that will cause the county to decrease or discontinue your benefits during the period in which they happen. Here are some examples:

- An adult in the household reaches the CalWORKs 48-month time limit;
- A household member is sanctioned/penalized;
- A child reaches the age of 18 (and will not graduate from high school before the age of 19);
- Someone in your household begins receiving benefits in another household;
- An eligible child is placed in Foster Care;
- Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

## YOUR REPORTING RESPONSIBILITIES (CONTINUED)

### CALFRESH CHANGE REPORTING

#### For CalFresh Change Reporting, you must report when:

1. Your total monthly income starts, stops, or changes by more than \$50.
2. Anyone's source of income changes.
3. Anyone moves into or out of your home.
4. Anyone joins or leaves your household.
5. You move or you get a new address.
6. Your rent and utility costs **only** if you move.
7. If there is a change in the amount of any court ordered child support paid by a member of the household for a child not living in the home.
8. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) CalFresh recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.
9. Any member of your household is avoiding or running from the law to avoid any felony prosecution, custody or confinement after conviction, or is found by a court to be in violation of probation or parole.
10. Any household member convicted of a drug-related felony after August 22, 1996, for manufacturing, sale or distribution of a controlled substance(s), or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities.

#### For CalFresh Change Reporting, you may report when:

1. Anyone's physical or mental illness begins or ends.
2. Anyone's citizenship/immigration status changes or anyone gets a letter, form or new card from the USCIS.
3. You have changes in your dependent care costs.
4. Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.
5. Any household member starts to pay court ordered child support for a child not living in the home.

### CalWORKs Annual Reporting for Certain Child-Only Cases (AR/CO)

Most CalWORKs cases where only the children get cash aid will only have to report once each year except for a few mandatory changes that must be reported within 10 days of when they happen. These cases are called Annual Reporting/Child-Only (AR/CO) cases. The County will tell you if you have an AR/CO case.

AR/CO cases will only have to report changes at their Annual RD, with the following exceptions:

- Anytime your family's combined gross income, both earned and unearned is more than the Income Reporting Threshold (IRT) for your family. The County will tell you in writing what your IRT is.
- Anytime someone moves into or out of your home. This includes newborns and children who are placed in foster care.
- Anytime you have an address change.
- Anytime that someone joins or is in your household that is convicted of a drug related felony, becomes a fleeing felon or is found by a court to be in violation of probation or parole and it was not already reported.

### CalWORKs AR/CO Cases Who Receive CalFresh

CalFresh households who are part of a CalWORKs AR/CO case will report semi-annually. See Pages 3 and 4 of this notice for semi-annual reporting responsibilities.

### Voluntary Reporting Information for CalWORKs AR/CO cases and CalFresh Change Reporting Households

You can also report some changes voluntarily. Reporting some changes may help your cash aid go up. See page 4 of this notice for more information about voluntary reporting.

## YOUR REPORTING RESPONSIBILITIES (CONTINUED)

### IMPORTANT INFORMATION CASH AID ONLY

#### Unemployed Parent

If you are applying for cash aid as an unemployed parent, the principal earner (PE) must:

- be unemployed and not have worked in the preceding 4 weeks
- apply for and accept any unemployment insurance you are eligible to get

The PE is the parent who has the most earnings in the past 24 months.

#### Homeless Assistance

You may be eligible for money to help pay for temporary shelter, permanent housing or to prevent eviction. This is a once-in-a-lifetime payment unless you meet an exemption. If you have already received homeless assistance and need it again, your worker will tell you if you are eligible.

#### School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children are attending school, and
- children under the age of 6 have received age appropriate immunizations. (MPP Sections 40-105.4; 40-105.5).

#### Maximum Aid Payment (MAP)

There are two levels of Maximum Aid Payment (MAP). Most families getting cash aid get the lower MAP level. Families may get the higher MAP level if each parent or caretaker in the Assistance Unit (AU):

- is disabled and getting Supplemental Security Income/ State Supplemental Payments (SSI/SSP), or In-Home Supportive Services (IHSS), or State Disability Insurance (SDI), or Temporary Workers Compensation (TWC), or Temporary Disability Indemnity (TDI) benefits
- is caring for an aided child(ren) who is not their child and the caretaker does not get cash aid.

Also eligible for the higher MAP:

- a family who gets Refugee Cash Assistance (RCA) if each adult meets an exception.

#### Maximum Family Grant (MFG) Rule

The MFG rule applies to any child born after August 31, 1997. The MFG rule says that your cash aid grant will not go up to include a child born to your family, if your family got cash aid for the 10 months in a row right before the child's birth. There are situations where the rule does not apply. Your worker will give you a copy of the MFG rules and answer your questions. Then you will sign a copy that says you understand the rules.

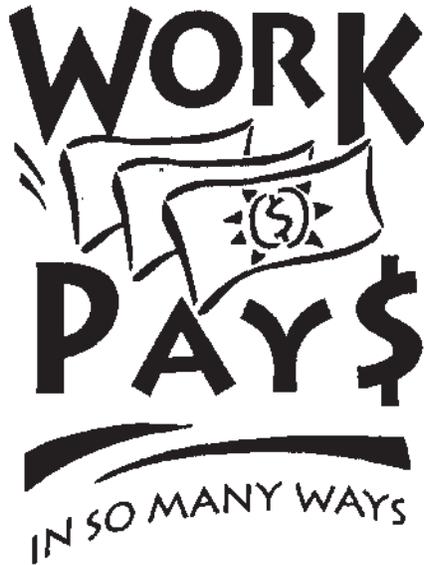
#### Proof of Facts

If you ask for cash aid within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for cash aid within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since you last got cash aid, the county will need new proof.



### Here's how **Work Pays**:

- Gives you more \$\$\$\$ to help support your family
- Builds a better life for you and your family
- Develops job skills
- Builds self-esteem
- Gives you personal satisfaction

### You can work and still get cash aid:

- ✓ In most cases, when you work, your gross earnings (earnings before deductions) are not subtracted dollar for dollar from your cash aid payment. You may be eligible for **work related deductions**. When you add it up, you have more \$\$\$\$ for your family.
- ✓ When you have a **grant-based on the job training (OJT)** assignment, all or part of your cash aid payment is used by your employer to help pay your wages. You do not get work related deductions for grant based OJT wages.
- ✓ Either way, you may be eligible for child care costs that are paid to your provider.

See page 8 for facts about work and training rules, work incentives, including child care programs. Ask your worker for more facts about **Work Pays** and how **grant-based OJT** can work for you.

**Remember, you can work and still get cash aid as long as you stay eligible and meet reporting rules in a timely manner.**

## Work and Training Rules

Your worker will tell you what cash aid and/or CalFresh work rules you need to follow before and after your application is approved. You may be required to be in work, training or education activities to keep getting your cash aid, CalFresh, or both. More than one member of a household can be required to follow cash aid and/or CalFresh work rules. If anyone becomes ineligible for not following work or training rules, other members of their household can still get cash aid or CalFresh, as long as they remain eligible. But the amount of cash aid or CalFresh they get may change.

## Cash Aid Work Rules

If you get cash aid and CalFresh benefits or just get cash aid, you will need to take part in certain Welfare-to-Work activities to keep getting your cash aid and CalFresh benefits. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules. Welfare-to-Work activities include, but are not limited to, subsidized or unsubsidized work, work experience, community service, adult basic education, vocational training, and job search. Subsidized means that the county or some other funding source pays your employer for part of your wages.

The cash aid work rules also say you must:

- Sign a Welfare-to-Work plan;
- Take a suitable job that is offered to you;
- Not quit a job or reduce your earnings.

## Sanctions for Not Meeting Cash Aid Work Rules

Any time you don't meet cash aid work rules and you don't have a good reason, your cash aid will be stopped until you do what you should do. After your cash aid is stopped or reduced, you can only get it back again if you meet the work rules that you had stopped meeting or if you become excused. If your cash aid is stopped, your CalFresh benefits may also be stopped or reduced.

## CalFresh Work Rules for Persons Not Receiving Cash Aid

If you only get CalFresh benefits, you may need to take part in certain employment and training activities to keep getting your CalFresh benefits. These activities include job search, workfare, adult basic education, and vocational training. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules.

The CalFresh work rules also say you must:

- Answer questions about your job experience and ability to work;
- Check on a possible job we tell you about and take a suitable job that is offered to you;
- Not quit a job or reduce the number of hours you work to less than 30 hours per week.

## CalFresh Only Penalties

If you don't meet CalFresh work rules and you don't have a good reason, your CalFresh benefits will be denied or stopped for one, three, or six months, depending on the number of times you stop meeting the rules. After your CalFresh benefits are stopped, you can only get them again at the end of the penalty or sooner if you become exempt.

## Work Requirement for Able-Bodied Adults Not Receiving Cash Aid

If you only receive CalFresh benefits and you don't have minor children, there is another work rule which you also may need to meet. You do not have to meet this work rule if you are under age 18, over age 49, pregnant, or you are part of a CalFresh household with a minor child. You may be excused for other reasons that your county worker can explain. The work rule says that if you are an able-bodied adult, you must work at least 20 hours a week or 80 hours a month in paid employment, take part in a workfare project for the required number of hours, or take part in an approved training activity for at least 20 hours per week or 80 hours per month. During a period of 36 months, CalFresh benefits will stop if there are three months in which you do not meet the work rule. If you stop meeting the work rule a second time for reasons such as being laid off, you may be able to get CalFresh benefits for three months in a row without having to meet the rule. After that you can only get CalFresh benefits if you meet the work rule or get excused.

## CalWORKs Income Disregards

The total amount of cash aid your family receives is based on your family size and any other income you may have. The law allows for some income to be disregarded when the total amount of cash aid you will receive is calculated.

- If your family gets more than \$225 a month of Disability Income (DI), only the first \$225 is disregarded.
- If your family gets \$225 a month or less of DI, none of it will be counted as income and if you also have Earned Income (EI), any remaining amount of the \$225 disregard, up to \$225, will not be counted as income.
- In addition, 50 percent of any other EI will be disregarded.
- The remainder is your net countable income and is the amount that will be used to figure your cash aid.

## Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

## CalWORKs Child Care Program

Child care benefits are available to recipients who need child care to work or participate in county-approved welfare-to-work activities such as attending education or job training programs.

## California Department of Education (CDE) Child Care

Child care benefits are also available from CDE. Contact your local Resource and Referral Agency for more information.

## Transitional Medi-Cal (TMC)

You may get Medi-Cal for up to 12 months if you go off cash aid because you are working. Your family must have gotten cash aid for at least three of the last six months before cash aid stopped. To get more than six months of TMC, your income must be under certain limits and you must meet TMC reporting rules.

## OTHER IMPORTANT INFORMATION

### CASH AID AND CALFRESH SEMI-ANNUAL REPORTING (SAR) HOUSEHOLDS Budgeting Rules

The amount of cash aid and/or CalFresh benefits you can get depends on your income and allowable expenses. You will get a Semi-Annual Eligibility Report (SAR 7) to fill out six months after your application and after every annual redetermination/recertification (RD/RC). On the SAR 7, you will need to report what income and expenses you had in the report month and any known changes you will have in the six months after you turn in your report. The report month will be on the top of your SAR 7. The income and expenses you have in the report month and any known changes will be used to figure the amount of cash aid and/or CalFresh benefits you can get for those six months. Information that you put on the SAR 7 about the report month will be used for the next six months if you don't expect your income or expenses to change.

For example, if you turn in a SAR 7 in March, you will report what income you had in February. You will also report any income changes you expect to have in April, May, June, July, August and September. If the income from February will stay the same, your cash aid and/or CalFresh benefits for April, May, June, July, August and September will be figured using that same income and expenses for each of those months. If your income and expenses will change, your worker will use the new income amounts you'll get in those months to figure your cash aid and/or CalFresh benefit amount for each month of the semi-annual period. This method is called prospective budgeting.

### CASH AID ANNUAL REPORTING (AR) CASES AND CALFRESH CHANGE REPORTING HOUSEHOLDS WITH A CALWORKS AR CASE Budgeting Rules

Annual Reporting (AR) households will also use prospective budgeting except you will not have a regular report form like the SAR 7 for SAR households. AR households will report on their annual RD/RC forms any income, expenses and property they have and any changes they are sure will happen in the next 12 months. The information you provide will be used to figure your cash aid and CalFresh benefits for the next 12 months. There are some things that you will have to report within 10 days of when they happen. The mandatory reporting rules for AR cases and CalFresh change reporting households with an AR case are on page 5 of this form.

### Property Limit CalWORKS:

There is a \$2000 limit on the value of the property (e.g. bank accounts, stocks, etc.) that your family can own and be eligible to receive CalWORKS benefits. If someone in your family is at least 60 years of age or disabled the limit is \$3250. Your residence and furniture are not part of the limit. You may own a vehicle worth up to \$4650. If your registered vehicle is worth more than \$4650, any value over that limit will count as part of your property limit unless the vehicle is used by your family for certain special reasons. Ask your worker what those reasons are. Any vehicle you have, that cannot be sold for more than \$1500, will not count towards your property limit. Your worker can explain to you how to figure the value of any vehicle.

### CalFresh:

For recipients who get both cash aid and CalFresh benefits the CalWORKS property limits (above) will apply. If you only get CalFresh benefits, the property limit for households without an elderly or disabled member is \$2000. The property limit for households with at least one member who is age 60 or older or disabled is \$3250.

The property limits may not apply if your household's gross income is not more than the CalFresh Income Reporting Threshold (IRT) for your household size. Your CalFresh IRT is 130 percent of the Federal Poverty Limit for your household size. The county will tell you the amount of your household's IRT.

### CASH AID ONLY 48-Month Time Limit

As of July 1, 2011 a parent or caretaker relative is not eligible for cash aid when he/she has received cash aid for a total of 48 months. All cash aid received from CalWORKS and/or cash aid received from Tribal TANF or any other state counts toward the 48-month total. Only cash aid received on or after January 1, 1998 counts toward the 48-month total. There are exceptions to this time limit and the limit does not apply to children.

### Resources/Electronic Benefits Transfer (EBT)

Any balance remaining in the EBT account at the end of the month will be considered an available resource and could make your household ineligible for cash aid if your total countable resources are more than the allowable resource limits.

### Transfer of Assets Rule

Recipients can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the family will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number.

### CALFRESH ONLY Utility Allowances

You will be allowed a Standard Utility Allowance (SUA) deduction if you have heating and cooling costs. If you have utility costs other than heating or cooling, such as water, sewer and garbage, you will be given a Limited Utility Allowance (LUA) deduction. If you only have a telephone cost, you will be given a Telephone Utility Allowance (TUA) deduction. The SUA, LUA and TUA are used to reduce your income, which helps you get more benefits.

### MEDI-CAL/34-COUNTY CMSP ONLY Spending Down Excess Property

- If you get or apply for Medi-Cal/34-County CMSP Only and you have more property than the rules allow, you may lower it by the last day of any month, including the month of application. For Medi-Cal you may spend your excess property in any manner you want. But you may not be eligible for nursing facility level of care for a period of time if you sell or give away any property for less than its worth, and you apply for or receive Medi-Cal nursing facility level of care within 30 months of the transfer.
- You may not be eligible for 34-County CMSP if you sell or give away any property for less than it is worth.

### Resources And Property

- All Medi-Cal benefits received after age 55 are subject to recovery from a deceased Medi-Cal recipient's estate. However, recovery may not exceed the value of the estate. Recovery may not occur if the beneficiary is survived by a spouse. The state may not claim the proportionate share of an estate left to a minor child or a totally disabled adult child. In addition if recovery would cause an undue hardship for any other heirs and that hardship can be demonstrated, recovery may be waived in full or in part.
- If you are institutionalized and your home or former home is not exempt, the state may record a lien against your property to repay the cost of medical care covered by Medi-Cal.

### AVAILABLE SERVICES

**Women, Infants and Children (WIC) Supplemental Nutrition Program:** The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

**Voter Registration:** If you want to register to vote, ask your worker to send you a registration form. If you need help filling it out, ask your worker. You can mail the form yourself. Your eligibility for aid will not be affected whether or not you register. Your worker will not tell you how to vote.

## PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than \$950 is wrongly paid out for cash aid, CalFresh benefits, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or CalFresh benefits.

### Disqualification Penalties

#### Cash Aid and CalFresh

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or CalFresh overissuance.

#### Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to \$10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

### CalFresh Only

If your household receives CalFresh benefits, it must follow these rules:

- Don't give wrong or incomplete facts to get or keep getting CalFresh benefits.
- Don't trade or sell your EBT card.
- Don't alter your EBT card to get CalFresh benefits you are not entitled to get.
- Don't use CalFresh benefits to buy ineligible items such as alcoholic drinks, tobacco, paper, or cleaning products.
- Don't use someone else's EBT card for your household.

### CalFresh Penalties

If you do not follow CalFresh rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to \$250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- you traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation;
- you traded or sold CalFresh benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;
- you traded or sold CalFresh benefits that were worth \$500 or more, your CalFresh benefits can be stopped forever;
- you filed two or more applications for CalFresh benefits at the same time and gave the county false identity or residence information, your CalFresh benefits can be stopped for 10 years.

## APPLICANT/RECIPIENT CERTIFICATION

- I understand that one of the intended purposes for the cash aid is to help meet the basic needs of my family, including housing, food, clothing.
- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or CalFresh, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A).

- I also certify that, if I applied for or get cash aid, I got a copy of the following:
    - Welfare to Work Informing Notice (WTW 5)

(APPLICANT/RECIPIENT'S INITIALS) \_\_\_\_\_

- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219 /CMSP 219 and its contents were explained to me.

## ELIGIBILITY WORKER'S CERTIFICATION

**I certify that the applicant/recipient appears to understand:**

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or CalFresh, and/or share of cost for Medi-Cal/34-County CMSP

**I also certify that the applicant/recipient was given a copy of:**

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- For cash aid:
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- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, CalFresh Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home, Registered Domestic Partner)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date

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