



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



EDMUND G. BROWN JR.
GOVERNOR

March 2, 2015

ALL COUNTY LETTER 15-28

REASON FOR THIS TRANSMITTAL

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

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALWORKS PROGRAM SPECIALISTS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CONSORTIUM PROJECT MANAGERS

SUBJECT: CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) REVISED FORMS: AR 3, SAR 3, SAR 7, SAR 7A, SAWS 2A SAR, CW 8A, CW 8, CW 2211, AND CW 2212

REFERENCE: TITLE 21 UNITED STATES CODE SECTION 862a; ASSEMBLY BILL (AB) 1468 (CHAPTER 26, STATUTES OF 2014); WELFARE AND INSTITUTIONS CODE SECTIONS 11251.3 & 18901.3; MANUAL OF POLICIES AND PROCEDURES (MPP) SECTIONS 40-107; 40-118; 40-173; 40-181; 44-316; 82-510; 82-828; ALL COUNTY WELFARE DIRECTORS LETTER DATED JULY 1, 2014; ALL COUNTY LETTER NO. 02-66; 04-59; 14-100

The purpose of this All County Letter (ACL) is to highlight recent changes to certain CalWORKs and CalFresh forms with reference to mandatory reporting of felony drug convictions, since it will no longer be required. This ACL also makes additional miscellaneous changes to the forms, which are explained below.

Federal law prohibits individuals who have been convicted of certain felony drug offenses from receiving Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) benefits, unless a state opts out, partially or entirely, through the enactment of state legislation.

The AB 1468 (Chapter 26, Statutes of 2014) fully opts California out from the lifetime prohibition in both CalWORKs and CalFresh, effective April 1, 2015.

AB 1468 enacts statutory changes in the CalWORKs program by amending Welfare and Institutions (W&I) Code section 11251.3 to state that people with felony drug convictions shall be eligible to receive CalWORKs benefits. For CalFresh, section 50 of AB 1468 enacts statutory changes in the CalFresh program by amending W&I Code section 18901.3 to state that individuals with felony drug convictions shall be eligible to receive CalFresh benefits. For both programs, if the person with a felony drug conviction is on probation or parole, he or she must be compliant with the terms of his or her probation or parole, including participation in a government recognized drug treatment program, if required.

The following forms have been modified to reflect those and additional required policy changes:

Revised AR 3

- Language has been added to the instructions regarding which types of proof to submit for both income information and changes in expenses. For both, clients are now provided with instructions to get support from the county if help is needed in obtaining proof.
- What was previously the information provided under the second box of items under “Mandatory Information” has been deleted. It is no longer necessary to provide the name of a person convicted of a drug felony, or the date of the drug felony conviction for either CalWORKs or CalFresh participants. Furthermore, additional clarity was added to state that a court must find that a participant is in violation of probation or parole.
- Under the sixth box of items of “Mandatory Information” items, “court-ordered” has been changed to “legally obligated” to more accurately reflect the nature of the obligation and the need to report.

Revised SAR 3

- Language has been added to the instructions regarding which types of proof to submit for both income information and changes in expenses. For both, clients are now provided with instructions to get support from the county if help is needed in obtaining proof.
- What was previously the information provided under the second box of items under “Mandatory Information” has been deleted. It is no longer necessary to provide the name of a person convicted of a drug felony, nor the date of the drug felony conviction for either CalWORKs or CalFresh participants.

Revised SAR 7

- Question 4 has been revised. What was previously number 4(A) has been deleted. That subsection requested information on households with any person with a felony drug conviction. Providing this information is no longer necessary. Because it has been deleted, questions 4 (A) through (C) have been changed to 4(A) through 4(B). The follow up questions below 4(A) and 4(B) have been revised to eliminate any reference to felony drug convictions.
- In addition, this form was updated to clarify income reporting for questions 9-12. Households must submit proof if they report a job loss or if they are no longer receiving money from any other source. Additionally, households must report any anticipated changes in income for the next six months, not just those changes reported for the data month. Reminder: CalFresh-only households are not required to answer CalWORKs-only questions 4 and 13.
- AB 2382 (Chapter 905, Statutes of 2014) removes the CalWORKs rule that counties track school attendance for children ages 6-16. Therefore, the eighth check-box in question 13 no longer asks about school attendance for this group.

Revised SAR 7A

- The instructions for question 4 have been revised. The instruction no longer asks participants to report information about felony drug convictions. Also, the “Drug Related Felony” and “Controlled Substance” definitions have been eliminated.
- The form was updated to clarify proof of job loss and proof of loss of unearned income.

Revised SAWS 2A SAR

- A statement was added on page 3 to advise CalWORKs applicants that they must report any changes within 5 days while their application is pending.
- Question 5 on page 3 of this form regarding fleeing felons and probation/ parole violators was revised to eliminate any reference to felony drug convictions. The change modifies the mandatory reporting section of the form to reflect that felony drug convictions are no longer mandatory reports by deleting the reference.

- Number 10 under Change Reporting Households on page 5 was removed because the lifetime ban for people with felony drug convictions no longer applies to any households.
- Changes have been made on page 6 to implement AB 2382, which removes the requirement that County Welfare Departments (CWDs) track regular school attendance for children ages 6-16. New language informs applicants and recipients of the state law that all children under age 18 must attend school.
- Changes have been made on page 9 to conform with AB 74 (Chapter 21, Statutes of 2013) and Senate Bill (SB) 98 (Chapter 358, Statutes of 2013), which changed the CalWORKs vehicle asset limit.
- Additionally, changes were made to the Program Penalties section of the SAWS 2A SAR to inform applicants and recipients of what actions or attempted actions are considered to be a crime and/or an intentional program violation and the potential penalties for doing so based on the revised definition of benefit trafficking for public benefits such as CalFresh and usage of the EBT card. This information is vital for Special Investigative Units, prosecutors and Administrative Law Judges when determining whether or not it is reasonably certain that a recipient knew they were committing a crime or misusing their benefits.

Revised CW 8A

- Question 11 has been reworded so that it is no longer a compound question. What was previously question 13 has been deleted because it is no longer necessary to provide information on a child who was convicted of a drug felony as an adult. The subsequent question, which was previously question 14, has been renumbered accordingly and is now question 13.
- Question 6(A) was deleted due to AB 2382.

Revised CW 8

- What was previously question 12 has been deleted. It is no longer necessary to report felony drug convictions pertaining to possession, use, or distribution of controlled substances, or provide details. The subsequent questions have been renumbered accordingly.

Revised CW 2211

- The language in this form has been revised. References to the SAWS 2 form have been updated to reflect the most current form, the SAWS 2 PLUS. Also, felony drug conviction language has been deleted from the list of mandatory reports because this information is no longer required.

Revised CW 2212

- The language in this form has been revised. References to the SAWS 2 form have been updated to reflect the most current form, the SAWS 2 PLUS. Also, felony drug conviction language has been deleted from the list of mandatory reports because this information is no longer required.

Camera Ready Copies and Translations

For camera-ready copies in English, contact the Forms Management Unit at 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.

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.

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 interpreter services if an applicant or recipient requests them. 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>

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If you have any questions regarding this ACL and the revised forms, please contact the CaWORKs Eligibility Bureau at (916) 654-1322 or the CalFresh Policy Bureau at (916) 654-1896.

Sincerely,

Original Document Signed By:

KÄREN DICKERSON, Chief
CaWORKs Employment and Eligibility Branch

RYAN FRUCHTENICHT, Acting Chief
CalFresh Branch

Attachments

MID-YEAR STATUS REPORT**For CalWORKs and CalFresh**

RECIPIENT'S NAME:	CASE NUMBER (IF KNOWN):	SOCIAL SECURITY NUMBER (OPTIONAL)
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Use this form to report mandatory or voluntary changes that have occurred since your last redetermination/recertification (RD/RC).

If you are reporting income information, please provide proof, such as, pay stubs; copies of checks; letters from agencies, etc. If you're having problems getting the proof and need help, call the county.

If you are reporting changes in expenses, please provide proof, such as, receipts; canceled checks, paid invoices; etc. If you're having problems getting the proof and need help, call the county.

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 receive CalWORKs, report the information marked CW. If you receive CalFresh, report the information marked CF. The change of address and voluntary information sections are for all households/assistance units.

CW 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 \$ _____.

CW Someone in my household is running from the law to avoid a felony conviction; running from the law, to avoid custody or confinement after a felony conviction; or has been found by a court to be in violation of probation or parole.
Name of person _____

CW/CF Someone moved into or out of my household. (Attach a separate sheet for additional persons.)
1. Did the person move In or Out? (circle one)
2. Name (First, Middle, Last) _____
3. Date of Birth (mm/dd/yyyy) _____
4. Relationship to you _____
5. Regularly purchase and prepare together? Yes/No (circle one)

CW/CF 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 receive free rent at this new address. I receive free utilities at this new address.
 My rent amount is \$ _____ per month. My utilities are \$ _____ per month.

See other side

MANDATORY INFORMATION - continued

- CF I have had a change in income (check one):
- Total monthly income has stopped.
 - Earned income changed by more than \$100.
 - Unearned income changed by more than \$50.
 - Source of income changed.
 - New income started.

CF A change has occurred in the amount of legally obligated child support.

CF Complete this section to report reduced work or training hours for Able-Bodied Adults Without Dependents:

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 legally prosecuted. 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 for the entire report month.

WHO MUST SIGN BELOW:

For CalWORKs: you, your aided spouse, CA Domestic Partner or the other parent (of cash aided children) if living in the home.

For CalFresh: the head of household, responsible 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

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're having problems getting the proof and need help, call the county.

If you are reporting changes in expenses, please provide proof, such as: receipts; canceled checks; paid invoices; etc. If you're having problems getting the proof and need help, call the county.

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 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.

I get free utilities at this new address.

My rent amount is \$ _____ per month.

My utilities are \$ _____ per month.

I share the rent; my share is \$ _____.

I have: Heating Cooling

I became homeless.

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

SAR 7 ELIGIBILITY STATUS REPORT



REPORT MONTH _____

TO KEEP YOUR BENEFITS COMING ON TIME, PLEASE SIGN THE FORM AFTER _____ 1st AND RETURN IT BY _____ 5th
SUBMIT MONTH SUBMIT MONTH

_____ CASE NUMBER HERE

NEED HELP? (County Specific instructions w/county url)

Worker Name: _____ (DIST. ID HERE)
Worker Phone: _____
County: _____
Street address: _____
City, State, Zip Code _____
BAR CODE: _____

Check the box if you would like to STOP getting any of the following: STOP my CalWORKs STOP my CalFresh
 STOP my Medi-Cal

1. Has anyone moved into or out of your home (including newborns) or did you move in with someone else since you last reported? Yes No (If yes, complete the section below)

Date of Move (mm/dd/yy)	Name (First, Middle, Last)	Date Of Birth	Relationship To You	Regularly Purchase And Prepare Food Together?
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO

2. Have there been any changes to your address since you last reported? Yes No (If yes, complete the section below)

New Address: _____ Date Moved: _____
Mailing Address (if different than above) _____

3. If you have moved since you last reported please fill out the section below:

Your rent or mortgage per month now? \$ _____	If paid separately, your property taxes and home insurance per month now? \$ _____
--	---

Do you have utility costs that are not included in your rent or mortgage payment? If so, check which ones:
 Phone Trash Water Electric/Gas Other heating or cooling costs

4. CalWORKs only: Is anyone in your home:
A. Running from an outstanding warrant?
B. Found by a court to be in violation of probation or parole?
 Yes No (If yes, complete the section below)

Name of person	A or B from above	In what state was the warrant issued, or did violation happen?	Date of warrant or violation

5. Medical Costs: If anyone who gets CalFresh and is 60 years old or older, or disabled, had an increase in medical costs please complete the section below and attach proof:

Who had the change? _____	Amount of increase: \$ _____
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6. Child Support: Did anyone who gets CalFresh have a change in the amount of child support they have to pay since they last reported? Yes No If yes, complete the section below and attach proof.

What was the amount paid in the Report Month? \$ _____
Who paid support? _____

7. Dependent Care: If anyone who gets CalFresh and either works, is looking for work, or is going to school, had an increase in out-of-pocket dependent care costs since they last reported, please complete the section below and attach proof:

What was the amount paid out-of-pocket in the Report Month? \$ _____
Who paid: _____ List dependent(s): _____

8. Did anyone: Get, buy, sell, trade or give away any property, land, homes, cars, bank accounts, money, payments (such as lottery/casino winnings, back benefits from social security), or other property items since last reported?
 Yes No (If yes, complete the section below and attach proof. If you need more space, attach a separate piece of paper).

Who?	Type of Property?	When?	Amount/Value?	<input type="checkbox"/> Bought <input type="checkbox"/> Sold <input type="checkbox"/> Gave Away <input type="checkbox"/> Spent
				<input type="checkbox"/> Got as a gift <input type="checkbox"/> Traded <input type="checkbox"/> Won <input type="checkbox"/> Other

9. **Did anyone get income from employment in the Report Month?** Yes No (If yes, complete the section below and **attach proof**). The **Report Month** is listed at the top of the first page. List each job for each person who works. If you need more space attach a separate piece of paper. Examples include babysitting, salary, self-employment, sick pay, tips, etc. **If you lost your job, attach proof.**

	Job #1	Job #2	Job #3
Name of person who got income:			
Source of income/Employer name:	Self-employed, check here <input type="checkbox"/>	Self-employed, check here <input type="checkbox"/>	Self-employed, check here <input type="checkbox"/>
How often paid:	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly
Gross amount of income they got in the report month:	\$ DATE(S) RECEIVED:	\$ DATE(S) RECEIVED:	\$ DATE(S) RECEIVED:
Hours worked per month:			

10. **Will there be any changes to your income from employment in the next six months (including income listed in #9)?**
 Yes No (If yes, explain here and **attach proof**). Examples: Stopping or starting a job; increase or decrease of income; changes in hours; quitting a job or going on strike; change in how often you are paid.

11. **Did anyone get money from any other source in the Report Month:** Yes No (If yes, complete the section below and **attach proof**.) The **Report Month** is listed at the top of the first page. Examples include: Social Security, Unemployment Compensation, Veteran's Benefits, State Disability Insurance (SDI), Child/Spousal Support, Worker's Compensation, Loans/Gifts, Earned/Unearned Housing, Utilities, Food, etc. If you no longer get money from a source you previously reported, **attach proof**.

Name	Source of income	One time payment or monthly	How much
			\$
			\$
			\$

12. **Will there be any changes to money received from any other source in the next six months (including money listed in #11)?**
 Yes No (If yes, explain here and **attach proof**). Examples of changes: An increase or decrease in income or benefits, or if you will start or stop getting income or benefits.

13. **CalWORKs only: Have any of the following happened to anyone in your home since you last reported?** Yes No (If yes, check below and **attach proof**):

- Family Change (Married, divorced, separated, entered into a California Registered Domestic Partnership (RDP), have a non-California Domestic Partnership (DP), ended a DP or RDP, became pregnant, or is no longer pregnant?)
- Job/Employment (Start, stop, quit a job, started a business or went on strike?)
- Disability (Became disabled or recovered from a disability or major illness?)
- Immigration (Citizenship or immigration status change, or got a new card, form, or letter from USCIS (INS)?)
- Insurance (Started, stopped, or changed health, dental, or life insurance benefits, including MEDICARE?)
- Custody (Any change in the amount of time you care for/have custody of your children?)
- In-Home Support Services (Started or stopped getting services?)
- School Attendance
*For Age 18 or older student- started or stopped school/college? (You may be able to claim costs for books, school transportation, etc.)
- Someone paid for all of my housing, food, clothing or utility costs. (please explain) _____
- Other _____

Please read carefully, sign, and date.

By signing this form:

- I understand and certify, under penalty of perjury, that all my answers on this report are correct and complete to the best of my knowledge.
- I understand the penalties for fraud are as follows: I may be sent to prison for up to 20 years and fined up to \$250,000. I may have to pay back benefits if I was not eligible to them. The first time I break the rules on purpose I will not be able to get CalFresh for one year; the second time two years; and after the third time I will not be able to get CalFresh again.
- I understand and agree to give copies of all documents needed to complete my semi-annual report.
- I understand that in some instances, I may be asked to give consent to the County to make whatever contacts are necessary to determine eligibility.

CERTIFICATION - FRAUD WARNING

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I may also be charged with committing a felony if more than \$950 in Cash Aid, and/or CalFresh is wrongly paid out as a result of such an action. I have received a copy of the Instructions and Penalties for the SAR 7 Eligibility Status Report for Cash Aid and CalFresh.

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

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, a responsible household member, or the household's authorized representative.

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

HOW TO FILL OUT YOUR SAR 7 ELIGIBILITY STATUS REPORT**For Cash Aid and CalFresh (formerly known as Food Stamp) Benefits**

Save this form to help you fill out your SAR 7 (Eligibility Status Report). If you need help filling out your report, **call the County**.

- If you do not send in a complete report, your benefits may be delayed, changed, or stopped, or cause an overpayment that you will have to pay back. You must answer all the questions, and attach proof when we ask for it. Questions 4 and 13 are CalWORKs only, households only receiving CalFresh are not required to answer these questions.
- **Attach a separate sheet of paper if needed.**
- **Facts you report may cause your benefits to go up, down, or be stopped.**

**INSTRUCTIONS****How Often You Must Complete the SAR 7**

Once a year; (6 months after your application/annual renewal). The County will tell you when your SAR 7 is due.

Reporting For People Who Are Living In Your Home if your family gets cash aid, report facts for:

- All **children**-natural, adopted, and stepchildren.
- All **parents**-natural, adoptive, and stepparent.
- Other **aided relatives** in the child's case.
- **Yourself** and your **spouse or registered domestic partner**.
- Anyone who is **temporarily absent** from the home.

If your family gets CalFresh (with or without cash aid) you must also report facts for:

- All children.
- All related adults.
- All other people in the household who regularly buy and prepare food with you.

Asking To Stop Benefits

- On the SAR 7, fill out the section to stop benefits **only** if you want to stop any of your benefits. Check the benefits you want stopped, and sign and date the SAR 7. *If you only want to stop some of your benefits and keep others, you must fill out the rest of the SAR 7.*
- You can also stop your benefits by contacting the County.
- If you ask to have your cash aid stopped, your Medi-Cal may also be stopped or changed. You may not be eligible for Medi-Cal or you may have to pay a share of cost for it.

HOW TO FILL OUT EACH QUESTION**Household information (Question 1)**

List any changes in who lives with you, changes to your address (including changes in apartment number, and changes in housing costs since you last reported). This includes: newborns; people who are temporarily absent from the home; or anyone who died, entered or left a hospital or institution (including jail or prison), etc.

Address Change/Housing Costs (Questions 2 and 3)

Give us the facts about any changes in your address or phone number since you last reported. If you are getting CalFresh, you may be asked to give proof of new housing costs like rent and utilities. If your costs have increased because of the move, be sure to list the new amounts. This may increase your CalFresh benefits.

Fleeing and Parole/Probation Violations (CalWORKs only) (Question 4)

This question applies to anyone already living with you who had any of these happen since you last reported. It is ALSO for anyone who moved into your household who is running from the law or in violation of parole/probation. We need the person's name, the place, and the date the warrant was issued or the violation occurred.

If you reported the information to the County before, you do not need to report the same information.

Expenses (CalFresh Information) (Questions 5, 6 and 7)

These questions may change your CalFresh benefits. This information may lower the income we count and increase your benefits. For people age 60 and older or who are disabled, report any changes to your out of pocket medical costs. For any CalFresh household, report changes to your costs for child or adult dependent care needed for work or training. If you pay child support, report any changes in the amount paid. **Attach proof to see if you can get more benefits.**

Property (Question 8)

List anyone who got, bought, sold, traded, spent or gave away any property. Property includes: land, home, cars, bank accounts, money payments (lottery or casino winnings, retroactive social security, tax refunds, etc). Include gifts and loans. List whose property, the type of property, when it changed, and the value of the property ("amount" on the form). Check the box for what happened. **Attach proof.**

If you have already reported and provided proof of new property, you do not have to report it again unless there has been a change.

Employment Income (Question 9)

List **all** income from employment (work) – earnings, tips, training allowances, benefits, or other earnings anyone got in the report month. List the amount before taxes or deductions (the gross amount). **Attach proof.**

- **Employment income** includes but is not limited to paychecks, cash income, vacation pay, bonuses, money from self-employment, temporary job or training income, rental income, IHSS, etc.
- If **self-employed**, you can get a 40% deduction for expenses without proof. If your expenses are higher and you want to claim actual expenses, list all business expenses on a separate sheet of paper. Attach proof if using actual expenses.
- **Proof of job loss** includes but is not limited to a letter from the employer, UIB award letter, or if no other verification is available, a signed written statement.

Changes in Employment Income (Question 10)

We need to know if income will continue or if there will be changes. If your income will stay the same, we will use the amount you report as your income for the next 6 months. If you know there will be changes in income, tell us why, how much and when. If you aren't sure, you can also report the change when it happens. For example, if you were offered a job and know your hourly wage and schedule, you must report this even if you haven't started working or been paid yet. Also, if you are working on-call or have a schedule that changes a lot, write this information on your SAR 7 form.

Proof of employment income includes but is not limited to: check stubs, copies of checks or statements from the employer etc., or tax statements for self-employed.

Other Income (Question 11)

List **all** other income from any other source. **Attach proof.**

- **Disability or Retirement income** includes SSI, Social Security, Veteran's disability benefits, worker's compensation or any other disability/retirement payments.
- **Unemployment benefits**
- **Other:** lottery winnings; insurance or legal settlements; gifts or loans; rental assistance; free housing/utilities/clothing/food (or if someone paid all of these costs for you); or anything else.
- **Proof of no longer receiving other monies** includes but is not limited to a letter from the benefit provider or if no other verification is available, a signed written statement.

List (1) who got the income, (2) where they got the money from, and (3) the amount they got.

Changes in Other Income (Question 12)

Tell us if you think the income will continue or if you know it will change. If you know it will change, tell us when it will change and how much.

SEE OTHER SIDE FOR MORE INFORMATION

Proof of other types of income includes but is not limited to: check stubs, copies of the checks, award letters from the agency you got the money from, etc.

Any Other Changes (CalWORKs only) (Question 13)

List other things that could change your eligibility or the amount of your benefits. Examples of changes you should report are listed on the SAR 7.

WHO MUST SIGN THE SAR 7

- For **Cash Aid:** You and your aided spouse, registered domestic partner, or the other parent (of cash-aided children), if they live in your home.
- For **CalFresh:** The head of household, authorized representative, or responsible household member.
- **And for Both:** Any other person who helps fill out the report, an interpreter, or the witness to your mark.

WHAT WE MEAN WHEN WE SAY

RUNNING FROM THE LAW: A person is considered avoiding or running from the law if an arrest warrant has been issued and the person knew or should have known from the facts that law enforcement was looking for them.

CASH AID: CalWORKs (California Work Opportunity and Responsibility to Kids), Refugee Cash Assistance (RCA), Trafficking and Crime Victim Assistance Program (TCVAP), and Entrant Cash Assistance (ECA).

CHILD SUPPORT PAYMENT: The payment you must make to a person for your child or stepchild. Include payments made by a stepparent living in your home.

COMPLETE SAR 7: A SAR 7 is “complete” only when:

- All of the YES/NO questions are answered, *and*
- All of the information is filled in, *and*
- All of the proof is attached when the form asks for it, *and*
- All of the required signatures are on the form, *and*
- The form is signed and dated after the last day of the report month.

GROSS AMOUNT: The amount of your paycheck or other check (unemployment benefit, retirement, etc.), before deductions are taken out for taxes, social security, etc.

IN VIOLATION OF PROBATION OR PAROLE: A court has found you to be in violation of the terms of your probation or parole. The original crime for which probation or parole was ordered could be for a felony or misdemeanor.

REPORT MONTH: The month shown at the top of the SAR 7. Report all income you got and any changes that happened in this month.

SUBMIT MONTH: The month you sign and date the report and turn it in. The submit month is shown at the top of the SAR 7, under the report month.

CERTIFICATION SECTION

- You must sign the SAR 7 “under penalty of perjury.” This means that you swear (promise) that the facts you give us are true, correct, and complete.
- Perjury is a crime – it means you swore (promised) to tell the truth and then you were dishonest.

REMEMBER:

- The report is due by the 5th of the submit month. Try to get it in on time to avoid problems with your benefits.
- If your report is late (after the 11th of the submit month), not complete or not turned in, your benefits may be late, changed, or stopped.

- If the County gets your report too late in the month to decrease your benefits based on what you reported, you may be charged with an overpayment and have to pay it back.
- If your report is not complete when you turn it in, you will be asked to complete the questions you did not answer and/or turn in the proof that the report asked for. Your benefits may be late.
- If you sign and date your report before the first day of the submit month, you will be asked to sign and date it again.
- If you are not sure how to report, what to report or what proof you need to send in, **ask the County.**
- If your cash aid stops, you may still be eligible for CalFresh benefits even if you are now employed.
- If your cash aid stops, you may still be eligible for no-cost or low-cost health coverage under Medi-Cal.

WELFARE FRAUD:

- Welfare fraud is when you fail to report information, or report the wrong information, on purpose in order to try to get more benefits.
- Fraud is a crime.

PENALTIES FOR CASH AID WELFARE FRAUD: If you are convicted of fraud or if you are disqualified for intentionally (on purpose) not reporting your eligibility information correctly, you may lose your share of the cash aid. How long you will lose it depends on what the crime was and whether you had committed fraud before. You may also have to pay a fine up to \$10,000 and/or be 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 time, 12 months for the second time, or **forever** for the third.
- For turning in more than one application to get aid for the same family members in a different case in the same time period: 2 years for the first conviction, 4 years for the second, and **forever** for the third.
- For conviction of felony welfare fraud penalties are: 2 years for extra benefits under \$2,000; 5 years for amounts of \$2,000 through \$4,999; 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; intentionally (on purpose) 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 or an administrative hearing.

PENALTIES FOR CalFresh FRAUD:

If you are convicted of fraud or if you are disqualified for intentionally (on purpose) not reporting your eligibility information correctly, your CalFresh 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 or prison for 20 years.

Your CalFresh can be stopped 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 identity or residence information, to try to get CalFresh benefits in more than one case at the same time. Your CalFresh benefits can be stopped for 10 years.

SEE OTHER SIDE FOR MORE INFORMATION



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.

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).

CalWORKs Applicants - If any of the facts you told the county change, you must report the new facts to the county within 5 days.

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 PLUS) 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. **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.
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 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 may change).

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.

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 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.

Immunizations

You must provide proof when requested by the county that:

- 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.

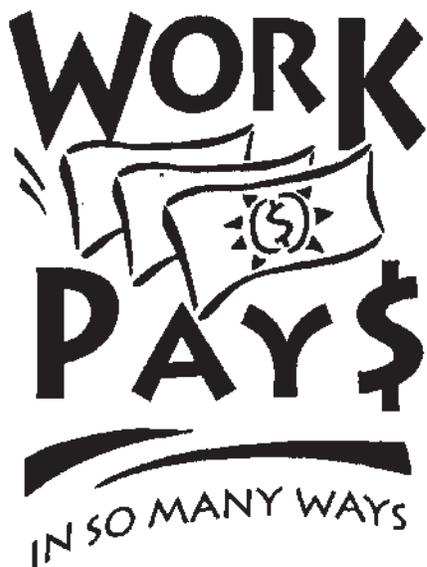
If you ask for cash aid within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

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

School Attendance

All children between the ages of six and 18 years of age who are getting aid must attend school.

If your child is between the ages of 16 and 18 years of age and is not attending school regularly, if he or she does not have a good reason, your grant can be lowered until he or she starts attending or meets an exemption.



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 \$2250 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 can own a vehicle (for example a car, truck, van, motorcycle, etc.) as long as what it's worth minus what you owe is less than \$9,500. If it was given to you as a gift, a donation, or a family member transferred it to you, we do not count it. You will be asked to give the County proof from the Department of Motor Vehicles that it was a gift, donation or transfer from a family member. The vehicle will not count if used by your family for certain special reasons. Ask your worker what those reasons are. 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 \$2250. 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

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.

Program Rules and Penalties

I understand I am committing an intentional program violation which may also be a crime, if I give false or wrong information, or if I do not give all the information on purpose to try to get benefits (CalFresh, cash aid and Medi-Cal) that I am not eligible to get, or to help someone else get benefits that they are not eligible for, or if I misuse my benefits (this is called trafficking). If I do this on purpose and get more than \$950 in benefits I was not eligible for, I can be charged with a felony.

In addition, I understand I must pay back any benefits I get that I was not eligible for or that I misused.

Program Violations

For CalFresh: I understand I may have committed an intentional program violation if I do any of the following:

- Use electronic benefit transfer (EBT) cards that belong to someone else or let someone else use my card
- Give false information about who I am or where I live
- Try to get dual benefits, for example, apply in two or more different counties or states at the same time
- Submit false documents for children or adult household members who are not eligible or who do not exist
- Violate conditions of my probation or parole
- Flee after a felony conviction
- Trade, buy, sell, steal or give away CalFresh benefits or EBT cards, or attempt to trade, buy, sell, steal or give away CalFresh benefits or EBT cards
- Trade CalFresh benefits, or attempt to trade CalFresh benefits for: cash; firearms; non-eligible goods, tobacco, explosives, ammunition, controlled substances such as drugs or alcohol
- Purchase (buy) a product with CalFresh benefits that has a return deposit, intentionally (on purpose) throw away the contents and return the container for the deposit amount, or attempt to return the container for the deposit amount
- Buy a product with CalFresh benefits and intentionally resell it for cash or anything other than eligible food

Penalties

I may lose CalFresh benefits:

- For one year for the first offense, two years for the second offense or forever
- Be fined up to \$250,000, imprisoned (be sent to jail/prison) up to 20 years or both

For cash aid: I understand I may have committed an intentional program violation and I may lose benefits if I do any of the following:

- Give false information about who I am or where I live
- Try to get dual benefits, for example, apply in two or more different counties or states at the same time
- Submit false documents for children or adult household members who are not eligible or who do not exist
- Violate conditions of my probation or parole
- Flee after a felony conviction

I may lose cash aid benefits:

- For six months, one year, two years, four years, five years or forever
- And be fined up to \$10,000 and/or sent to jail/prison for up to five 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:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A)

- For cash aid:

Welfare to Work Informing Notice (WTW 5)

- 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

APPLICANT/RECIPIENT CERTIFICATION

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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

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? A. Was the child placed in your home under a dependency order from the court? B. Do you want the foster child and foster care income counted on the CalFresh case? C. Is the child enrolled in a health care plan?

4. Did the child get cash aid or CalFresh this month? If "YES", complete below:

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

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:

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. Is the child pregnant or a teen parent? 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):

B. Has the child received a cash bonus or sanction, or help with child care, transportation, etc, from the Cal-Learn Program? 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? If "YES", complete below:

NAME OF PARENT PARENT A U.S. CITIZEN BRANCH OF SERVICE DATES OF SERVICE HONORABLE DISCHARGE YES NO YES 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 CF Non-HH Excl. Member Code: Yes No

Work Registration/Exemption Codes:

WtW: CF:

VERIF: Blind/Deaf/Disabled SSN 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 Date Initiated YES NO

CF: Honorable Discharge YES NO

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:				<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY												
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													
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:				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Verification provided Health Coverage Code:												
11. If the child has been charged as an adult with a felony, 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?				<input type="checkbox"/> YES <input type="checkbox"/> NO													
12. Has the child been found by a court of law to be in violation of probation or parole?				<input type="checkbox"/> YES <input type="checkbox"/> NO													
13. 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).				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> <tr> <td>• Do you want more facts about CHDP services?.....</td> <td></td> <td></td> </tr> <tr> <td>• Do you want free CHDP medical or dental services?.....</td> <td></td> <td></td> </tr> <tr> <td>• Do you need help making appointments or getting to the doctor or dentist?.....</td> <td></td> <td></td> </tr> </table>		YES	NO	• Do you want more facts about CHDP services?.....			• Do you want free CHDP medical or dental services?.....			• Do you need help making appointments or getting to the doctor or dentist?.....			<input type="checkbox"/> CHDP brochure and explanation given <input type="checkbox"/> CHDP Referral <input type="checkbox"/> Date:
	YES	NO															
• Do you want more facts about CHDP services?.....																	
• Do you want free CHDP medical or dental services?.....																	
• Do you need help making appointments or getting to the doctor or dentist?.....																	
B. Do you want more facts about immunization services?					<input type="checkbox"/> Referred for Immunization												
C. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs?.....					<input type="checkbox"/> Other services referral <input type="checkbox"/> Pregnant												
D. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help?.....					<input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum												
E. Is anyone breastfeeding a child? If "YES", was the birth within the last 12 months?					<input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning info given Date Referred:												
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?.....																	

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"/> Informing (CW 101 / TEMP CW 101A) Regs Met: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> ELIGIBLE	Eligibility Conditions Met - Date:	Authorization Date:	Effective Date of Aid:		
Signature of County Worker			Date	Signature of Supervisor	
				Date	

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

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 <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Not Attending School (Explain):
----------------------------------	--	--

MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER NAME USED: (Maiden, adoptive, etc.)
---	---

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?
 CF If "YES", explain: YES NO

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

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

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

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

LIST NAME, BRANCH OF SERVICE, ETC.	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------------	---

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

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

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	COUNTY USE ONLY 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	
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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:														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">WHY</td> <td style="width:33%;">WHEN</td> <td style="width:33%;">WHAT COUNTY/STATE</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </table>	WHY	WHEN	WHAT COUNTY/STATE											
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														
CF ⑫ 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 ⑬ 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 ⑭ 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 style="width:25%;">CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both</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> </table>	CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="3">Household Elects</th> </tr> <tr> <td style="width:33%;">BOARDER</td> <td style="width:33%;">HH MEMBER</td> <td style="width:33%;">ROOMER</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	Household Elects			BOARDER	HH MEMBER	ROOMER			
CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY											
Household Elects														
BOARDER	HH MEMBER	ROOMER												
CF ⑮ Does he/she get food from any of the following programs? ● Communal dining facility for the elderly or disabled ● Food distribution program operated by a Native American reservation ● Other food program If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO														
NAME OF PROGRAM														

CA CF	16 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).	COUNTY USE ONLY															
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 Verification(s) on file: <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: _____																	
CA CF	17 A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	Child Care Informing Given to Client: Trustline Informing (CCP 2) <input type="checkbox"/> Yes <input type="checkbox"/> No Health & Safety Certification (CCP 5) <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Care Eligible CA <input type="checkbox"/> Yes <input type="checkbox"/> No CF <input type="checkbox"/> Yes <input type="checkbox"/> No															
NAME OF PERSON WHO RECEIVES CARE _____ NAME OF PERSON WHO GIVES CARE _____ MONTHLY AMOUNT PAID \$ _____																	
NAME OF PERSON WHO RECEIVES CARE _____ NAME OF PERSON WHO GIVES CARE _____ MONTHLY AMOUNT PAID \$ _____																	
CA CF	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	18 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> <tr> <td colspan="3"> <input type="checkbox"/> CA: 30 days <input type="checkbox"/> CF: 60 days </td> </tr> </table>		YES	NO	Emp. Statement			Good Cause Determ			Voluntary Quit			<input type="checkbox"/> CA: 30 days <input type="checkbox"/> CF: 60 days		
	YES	NO															
Emp. Statement																	
Good Cause Determ																	
Voluntary Quit																	
<input type="checkbox"/> CA: 30 days <input type="checkbox"/> CF: 60 days																	
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.																	
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	19 Is he/she on strike? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	Striker Regs Apply CA <input type="checkbox"/> Yes <input type="checkbox"/> No CF <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	20 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	21 Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	<input checked="" type="checkbox"/> if Exempt CA CF															
TYPE BENEFIT _____ AMOUNT \$ _____ DATE APPLIED _____ WHERE (COUNTY/STATE) _____ DATE LAST RECEIVED _____ HOW OFTEN (Weekly, Monthly, Etc.) _____ DATE EXPECTED TO START AND STOP START: _____ STOP: _____																	
Will this income continue? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain any changes here: _____																	

CA 22 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 23 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 24 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 25 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 26 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 27 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 28 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
 \$ _____

<p>CA 29 Did he/she get medical/ pregnancy treatment this month or in the three months before this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">NAME OF PERSON RECEIVING CARE</th> <th rowspan="2">MONTHS OF CARE</th> <th colspan="2">WAS PAYMENT MADE FOR TREATMENT?</th> <th colspan="2">WANT MEDI-CAL FOR THOSE MONTHS?</th> </tr> <tr> <th>YES</th> <th>NO</th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <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> </tbody> </table>	NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?		YES	NO	YES	NO													<p>COUNTY USE ONLY</p> <p>Retro Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No Approved <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
NAME OF PERSON RECEIVING CARE			MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?																									
	YES	NO		YES	NO																										
<p>CA 30 Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>NAME OF INSURANCE COMPANY</th> <th>PREMIUM AMOUNT</th> <th>HOW OFTEN PAID</th> </tr> </thead> <tbody> <tr> <td> </td> <td>\$</td> <td> </td> </tr> <tr> <td> </td> <td>\$</td> <td> </td> </tr> </tbody> </table>	NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID		\$			\$		<p><input type="checkbox"/> DHS 6155</p>																					
NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID																													
	\$																														
	\$																														
<p>CA 31 Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>TYPE OF PROBLEM</th> <th>DATE PROBLEM STARTED</th> <th>EXPECTED DATE OF RECOVERY</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY				<p>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</p>																								
TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY																													
<p>CA 32 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:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>If "YES", explain:</p>		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)						<p>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</p>
	YES	NO		YES	NO																										
Special diet--prescribed by a doctor			Very high use of utilities																												
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Special telephone or other equipment			Other (specify):																												
Housework (no one in the home can do it)																															
<p>CA 31 B. Does he/she get In-Home Supportive Services (IHSS)? <input type="checkbox"/> YES <input type="checkbox"/> NO CF If "YES", how much does he/she pay each month? \$ _____</p>	<p><input type="checkbox"/> DFA 285-C</p>																														
<p>CA 33 The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility. CF Check (✓) each item YES or NO.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>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. <ul style="list-style-type: none"> • Do you want more information about CHDP Services? • Do you want CHDP medical services? • Do you want CHDP dental services? • Do you need help making appointments or with transportation to CHDP Services? </td> <td> </td> <td> </td> </tr> <tr> <td>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?</td> <td> </td> <td> </td> </tr> <tr> <td>C. Is anyone in the family breastfeeding a child? If "YES", was the birth within the last 12 months? 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.</td> <td> </td> <td> </td> </tr> <tr> <td>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.</td> <td> </td> <td> </td> </tr> </tbody> </table>		YES	NO	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. <ul style="list-style-type: none"> • Do you want more information about CHDP Services? • Do you want CHDP medical services? • Do you want CHDP dental services? • Do you need help making appointments or with transportation to CHDP Services? 			B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?			C. Is anyone in the family breastfeeding a child? If "YES", was the birth within the last 12 months? 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.			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.			<p><input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> Referral</p> <p><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</p> <p><input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date _____</p>															
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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.
- 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

Client Name _____
 Case Number _____
 Date _____
 County _____
 County Phone Number _____

Your CalWORKs Reporting Rules Have Changed. **Please Read This Carefully.**

As of _____ (date), your CalWORKs case will change from Semi-Annual Reporting to Annual Reporting. This is because your case no longer includes aid for an adult. You will no longer have to complete the SAR 7 once a year. You will now only have to report once per year on your annual redetermination form (SAWS 2 PLUS).

This won't be new as these were on-going SAR cases.

This notice has details on the Annual Reporting requirements. Ask your worker or call the County if you have questions about what to report and when.

You will get a separate notice about any changes to your CalFresh reporting requirements.

Reporting Rules

Under Annual Reporting you have no form you have to fill out and return other than the annual redetermination.

You still will get an appointment letter in the mail when your redetermination is due. Your aid will stop if you miss your redetermination appointment and don't make it up by the end of the month.

Example: On March 18, you get an appointment letter from the county that says your redetermination appointment is on April 4. If you miss the appointment and don't make it up by the end of the April, your case will be discontinued April 30th.

Income Reporting Threshold (IRT) Rules

You still need to report within 10 days if your total monthly income is more than the IRT amount. You have to report the income to the County **within 10 days**. By "total monthly income" we mean **any** money you get. Any time your IRT amount changes, the County will tell you in writing what the new income level is.

Under Annual Reporting, when you report income over your IRT, the County may lower or stop your benefits.

Example: If your IRT is \$900 and you get income of \$800 you do not have to report the change until your next redetermination. If you get income of \$901 or more, you must report it to the county within 10 days. Your benefits will go down or stop. The County will give you a notice 10 days before the change. If your benefits are lowered, the County will also tell you your new IRT amount.

Mandatory Reporting Rules

Under Annual Reporting, you must report anytime someone moves into or out of your home. Annual Reporting rules say you **MUST** report the following mid-year changes, verbally or in writing, within 10 days of the change:

- income over the IRT;
- someone moves into or out of your household;
- address changes;
- fleeing felon status; or
- a court finding that anyone violated a condition of probation or parole.

Voluntary Reporting Rules

There is no change to CalWORKs voluntary reporting rules under Annual Reporting. You may voluntarily report any information (such as a decrease in income) that may increase your grant amount.

Welfare-to-Work Reporting Rules

If you get Welfare-to-Work services, you must continue to turn in all other reports and verifications required by the county. You need to turn in this proof to keep getting services like child care, transportation, and money for books.

Client Name _____
 Case Number _____
 Date _____
 County _____
 County Phone Number _____

The Rules for Your CalWORKs Case Have Changed. **Please Read This Carefully.**

As of _____ (date), your CalWORKs case will change from Annual Reporting to Semi-Annual Reporting because your case now includes aid for an eligible adult. Under Semi-Annual Reporting, you are required to report two times per year instead of one time per year. One of those reports will be your annual redetermination/recertification form (SAWS 2 PLUS). Six months after you complete your SAWS 2 PLUS, a semi-annual eligibility status report (SAR 7) will be mailed to you and will tell you when it is due. You do not have to report when someone moves into or out of your home until your next report (SAWS 2 PLUS or SAR 7) is due. The Income Reporting Threshold (IRT) rules are the same under Semi-Annual Reporting: when you report income over your IRT, the county can decrease or stop your benefits.

This notice has details on the Semi-Annual Reporting requirements. Ask your worker or call the county if you have questions about what to report and when.

You will receive a separate notice about any changes to your CalFresh reporting requirements.

Reporting Rules

Under Annual Reporting, you were only required to complete a yearly redetermination of benefits. Under Semi-Annual Reporting, in addition to the annual redetermination, you are required to turn in a SAR 7 once a year (6 months after your annual redetermination). The SAR 7 will be sent to you in the mail.

Just like Annual Reporting, you will receive an appointment letter in the mail when your redetermination is due. If you miss your redetermination appointment and don't make it up by the end of the month, your aid will stop.

Example: On March 18, you receive an appointment letter from the county that says your redetermination appointment is on April 4. If you miss the appointment and don't make it up by the end of April, your case will be discontinued April 30th.

Income Reporting Threshold (IRT) Rules

The amount of income that you have to report within 10 days will remain the same under Semi-Annual Reporting. If your total monthly income is more than your IRT amount, you have to report the income to the county within 10 days. By “total monthly income” we mean any money you get. The county will tell you what your IRT is. Under Semi-Annual Reporting, the IRT is still based on your total income and the number of people in your household. Going over IRT can result in a decrease to your grant or your aid being stopped.

Example: If your IRT is \$1000 and you get income of \$800 you do not have to report the change until your next report (SAR 7 or SAWS 2 PLUS). If you get income of \$1001 or more you must report it to your worker within 10 days. If the income will continue, your cash aid benefits will be lowered or stopped with 10 day notice.

Mandatory Reporting Rules

Most CalWORKs mandatory reporting rules are the same under Semi-Annual Reporting as under Annual Reporting. Semi-Annual Reporting rules say you **MUST** report the following changes, verbally or in writing, within 10 days of the change:

- income over the IRT;
- address changes;
- fleeing felon status; or
- violations of conditions of probation or parole.

Voluntary Reporting Rules

There is no change to CalWORKs voluntary reporting rules under Semi-Annual Reporting. You may voluntarily report any information (such as a decrease in income or someone without income moving into your home) that may increase your grant amount. If you report something voluntarily that would result in a decrease to your grant amount, the county will not reduce your aid until you report the information on your next mandatory report.

Welfare-to-Work Reporting Rules

If you get Welfare-to-Work services, you must continue to turn in all other reports and verifications required by the county. You need to turn in this proof to keep getting services like child care, transportation, and money for books.