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STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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ARNOLD SCHWARZENEGGER
GOVERNOR

December 23, 2009

ALL COUNTY INFORMATION NOTICE I-89-09

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 FOOD STAMP COORDINATORS
ALL CalWORKs PROGRAM SPECIALISTS

SUBJECT: REVISIONS TO FOOD STAMP FORMS FS 26 AND FS 27

The purpose of this letter is to provide counties with information regarding revisions to the FS 26, Food Stamp Program Qualifying Drug Felon Addendum, and the FS 27, Non-Assistance Food Stamps (NAFS) Household Recertification Form. (See attached)

- Food Stamp Program Qualifying Drug Felon Addendum

The FS 26 was developed as a result of Assembly Bill 1796 and was used for situations involving a drug felony conviction when the form DFA 285-A2 was not being used, e.g., in situations where a new household member is being added to increase household size. This form may also be used when additional information is needed on a drug-related felony conviction. The FS 26 was inadvertently obsoleted, but is being reinstated as requested by counties.

- Non-Assistance Food Stamps (NAFS) Household Recertification Form

The form FS 27 was developed for use at recertification in lieu of the DFA 285-A1/A2, Food Stamp Application for NAFS households who are subject to Quarterly Reporting/Prospective Budgeting. Revisions were made to include drug/fleeing felon language. This form is not required, but may be used at recertification at county option. The FS 27, used along with the QR7, Quarterly Income Report, is an option counties can elect to complete the recertification process.

Camera-Ready Copies and Translations

For a camera-ready copy of English and Spanish forms, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has Internet access, you may obtain these forms from the CDSS web page at:

www.dss.cahwnet.gov/cdssweb/On-lineFor_271.htm.

Per MPP section 21-115.2, all other translations will be posted on our website on an ongoing basis. Copies of the translated forms and publications in all other required languages can be obtained at:

www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

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

Should you have any questions, please contact Alicia Thomason of the Policy Implementation Unit at (916) 657-2630, or by e-mail at: alicia.thomason@dss.ca.gov.

Sincerely,

Original Document Signed By:

CHRISTINE WEBB-CURTIS, Chief
Food Stamp Branch
Welfare to Work Division

Attachments

FOOD STAMP PROGRAM QUALIFYING DRUG FELON ADDENDUM

You may be eligible for food stamp benefits even though you or a member of your household have been convicted of a drug-related felony. Please answer the following questions and then read and sign this form. If you have any questions, please contact your worker.

<p>1. Since August 22, 1996, have you or a member of your household been convicted of a drug-related felony that has not been expunged? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, complete the questions below:</p> <p>Have you been convicted of:</p> <ul style="list-style-type: none"> • Transporting, importing into this state, selling, furnishing, administering, giving away, possessing for sale, purchasing for the purposes of sale, manufacturing, or processing precursors with the intent to manufacture a controlled substance or cultivating, harvesting, or processing marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No • Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If Yes, please complete the questions below.</p>	<p>County Use Column</p>
<p>2. Have you or any member of your household:</p> <p>a) Completed a government recognized drug treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Participated in a government recognized drug treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Enrolled in a government recognized drug treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Been placed on a waiting list for a government recognized drug treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e) Ceased the use of controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please attach proof or talk to your worker if you have questions.</p>	<p>Proof provided: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Food Stamp Fraud Penalties

There are new food stamp fraud penalties.

I understand that if I am convicted of an Intentional Program Violation, for having given wrong facts or incomplete facts, I can be disqualified for **one year** for the **first violation** and **two years** for the **second violation** and **forever** for the **third violation**. If I am found guilty in any court of law of having traded food stamp benefits for a controlled substance, I will be disqualified for **two years** for the **first violation** and **forever** for the **second violation**.

If I trade or sell food stamp benefits worth \$500 or more, I can be disqualified **forever**.

APPLICANT/RECIPIENT CERTIFICATION

I have completed the questions above and read all the information. I understand the new food stamp rules and penalties apply to my application or reapplication for food stamps. I understand the new rules and agree to comply with them. **I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this form is true, correct and complete.**

SIGNATURE ADULT HOUSEHOLD MEMBER (AUTHORIZED REPRESENTATIVE)	DATE
WITNESS IF YOU SIGN WITH AN X	DATE
ELIGIBILITY WORKER SIGNATURE	DATE

NON-ASSISTANCE FOOD STAMPS (NAFS) HOUSEHOLD RECERTIFICATION FORM

This form can be used at recertification in lieu of the DFA 285-A1/A2 Food Stamp Application for Non-Assistance Food Stamp households who are subject to Quarterly Reporting/Prospective Budgeting.

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

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

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

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

Are you homeless? YES NO

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

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

EXPEDITED BENEFITS

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

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

List all your household income below:

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

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

A. ETHNICITY

Are you Hispanic or Latino? YES NO

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

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

C. PRIMARY LANGUAGE

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

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

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

Check all that apply:

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

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

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

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

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

If YES, complete the following:

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

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

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

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

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

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

NAME	EXPLAIN

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

NAME	EXPECTED DUE DATE

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

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

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

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

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

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

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

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Cash or checks • Mortgages • Employee deferred compensation • IRA or Keogh Plans • Retirement Funds • Certificate Deposit | <ul style="list-style-type: none"> • Checking or Saving accounts • Oil, mining or mineral rights • Sales contracts • Trust funds • Stocks, Bonds | <ul style="list-style-type: none"> • Money Market accounts • Credit Union accounts • <u>Other</u> |
|--|---|--|

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

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

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

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

NAME	EXPLAIN	NAME	EXPLAIN

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

NAME	EXPLAIN	NAME	EXPLAIN

13. Since August 22, 1996, have you or any member of your household been convicted of a drug-related felony that has not been expunged? YES NO

If Yes:

NAME

DATE CONVICTED

If No, go to question #15. _____

Was the conviction for any of the following:

- Transporting, importing into this state, selling, furnishing, administering, giving away, possessing for sale, purchasing for the purposes of sale, manufacturing, or processing precursors with the intent to manufacture a controlled substance or cultivating, harvesting, or processing marijuana? YES NO
 - Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? YES NO
14. **Have you or any member of your household:**
- a) Completed a government recognized drug treatment program? YES NO
 - b) Participated in a government recognized treatment program? YES NO
 - c) Enrolled in a government recognized drug treatment program? YES NO
 - d) Been placed on a waiting list for a government recognized drug treatment program? YES NO
 - e) Ceased the use of controlled substances? (Must show proof to your worker) YES NO

If YES, please explain: _____

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

If you would like to authorize someone, complete below:

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE NUMBER

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

APPLICANT/RECIPIENT CERTIFICATION

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

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

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

SIGNATURE

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

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