STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF SOCIAL SERVICES
(916) 322-6636

August 18, 1980

ALL-COUNTY INFORMATION NOTICE NO. I-87-80

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: Forms APSB 201 (Statement of Facts Supporting Eligibility)
APSB 202 (Plan for Self-Support Questionnaire)

Attached are copies of Forms APSB 201 (revised) and APSB 202 (new). Both are now available and may be ordered by submitting a GEN 727B to the State Department of Social Services Warehouse, 6150 27th Street, Sacramento, CA 95822.

APSB 201

This form is now printed with a larger type which will be beneficial to both the applicant and the worker. This form reflects the recent state regulation change (MPP Section 22-009) which allows a recipient 90 days rather than one year to file for a state hearing.

APSB 202

This Questionnaire was designed to provide standard guidelines with which consistent decisions can be made in determining an acceptable plan of self-support. The form contains sufficient details to provide county workers with adequate information to make sound eligibility determinations. Counties are urged to utilize the APSB 202 to help determine applicants' ultimate objectives and the steps necessary to obtain their goals.

Questions regarding use of these forms should be directed to the County Adult Program Operations Bureau at (916) 322-6636.

Sincerely,

Kyle S. McKinsey

KYLE S. McKINSEY
Deputy Director

cc: CWDA

Attachments

AID TO THE POTENTIALLY SELF–SUPPORTING BLIND (APSB) PROGRAM – PLAN FOR SELF–SUPPORT QUESTIONNAIRE

CASE NUMBER

① CLIENT'S NAME | SOCIAL SECURITY NUMBER * | SEX ☐ MALE ☐ FEMALE

ADDRESS | TELEPHONE NUMBER | BIRTH DATE (MONTH/DAY/YEAR)

② GENERAL HEALTH

☐ GOOD ☐ OTHER DESCRIBE

③ EDUCATION AND TRAINING

CIRCLE HIGHEST GRADE COMPLETED

1 2 3 4 5 6 7 8 9 10 11 12

HIGH SCHOOL GRADUATE ☐ YES ☐ NO

COLLEGE GRADUATE ☐ YES ☐ NO

DESCRIBE VOCATIONAL OR OTHER SPECIAL TRAINING

DEGREES/CERTIFICATES RECEIVED

④ WORK EXPERIENCE – PRESENT EMPLOYMENT | EMPLOYMENT BEFORE BECOMING BLIND | EMPLOYMENT SINCE BECOMING BLIND

⑤ OBJECTIVE OF PLAN – DESCRIBE IN DETAIL, E.G. ("TO OBTAIN A MULTIPLE–SUBJECT CREDENTIAL AND BE EMPLOYED BY THE SACRAMENTO CITY UNIFIED SCHOOL DISTRICT.")

⑥ IF PLAN INCLUDES FULL TIME ATTENDANCE AT COLLEGE OR OTHER TRAINING FACILITY, COMPLETE THE FOLLOWING

NAME OF FACILITY

LOCATION | UNITS TAKEN | HOURS ATTENDING

ACADEMIC DEGREE/CERTIFICATE SOUGHT | EXPECTED COMPLETION DATE

⑦ STEPS AND RESOURCES NECESSARY TO ACHIEVE GOAL

STEP 1.

EXPECTED COMPLETION DATE | RESOURCES NEEDED FOR THIS STEP

SPECIFY RESOURCES AVAILABLE/SET ASIDE FOR THIS STEP

APSB 202 (6/80)

* THE SOCIAL SECURITY NUMBER IS REQUIRED IN THE ADMINISTRATION OF THIS PROGRAM (P.L. 94–455 AND EAS 40–105).

STEP 2

EXPECTED COMPLETION DATE	RESOURCES NEEDED FOR THIS STEP

SPECIFY RESOURCES AVAILABLE/SET ASIDE FOR THIS STEP

STEP 3

EXPECTED COMPLETION DATE	RESOURCES NEEDED FOR THIS STEP

SPECIFY RESOURCES AVAILABLE/SET ASIDE FOR THIS STEP

(8) SOURCE(S) OF FUNDS AND PROGRESS TO DATE (IF NO SOURCE AVAILABLE EDUCATION AND/OR BUSINESS VENTURE WOULD PROBABLY BE IMPOSSIBLE)

TYPE OF INCOME	AMOUNT OF INCOME $

OTHER REAL AND/OR PERSONAL PROPERTY SET ASIDE FOR USE IN THE PLAN

(9) JOB AVAILABILITY: IS THERE EMPLOYMENT AVAILABLE WITHIN THE COMMUNITY REQUIRING THE SKILLS/TRAINING THAT WILL BE ACQUIRED BY THE RECIPIENT DURING THE COURSE OF HIS/HER PLAN.

☐ YES ☐ NO IF YES, WHAT KIND

IF NOT, IS THE APPLICANT WILLING TO MOVE TO ANOTHER COMMUNITY?

☐ YES ☐ NO IF YES, WHERE?

(10) EXPECTED/PROBABLE INCOME WHEN GOAL IS REACHED (USE COMPARABLES WITHIN COMMUNITY: IF NO GREATER THAN APSB GRANT, PLAN IS QUESTIONABLE)

(11) APPROVAL OF PLAN ☐ GRANTED ☐ DENIED	DATE

IF DENIED, STATE REASON FOR DENIAL

APPLICANT'S SIGNATURE	WORKERS SIGNATURE

FOR COUNTY USE ONLY

DO YOU OR YOUR SPOUSE RECEIVE ANY OF THE FOLLOWING FREE OR IN EXCHANGE FOR WORK THAT YOU DO?
CHECK EACH ITEM. IF YES, EXPLAIN.

ITEM RECEIVED	YES	NO	NAME OF PERSON RECEIVING ITEM	HOW OFTEN RECEIVED	VALUE OF ITEM
A. HOUSING OR RENT	☐	☐			$
B. UTILITIES	☐	☐			$
C. FOOD	☐	☐			$
D. TRANSPORTATION	☐	☐			$
E. OTHER	☐	☐			$

DO YOU LIVE IN: (Check appropriate box)

☐ A house you own or are buying
☐ A mobile home you own or are buying
☐ Someone else's home
☐ A rented house or apartment
☐ A board and care home or guest home
☐ A hotel or rooming house
☐ A nursing home or hospital
☐ Other (Describe)

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE?

☐ YES ☐ NO IF YES, WHAT IS DOCTOR'S NAME?

DOCTOR'S ADDRESS	TELEPHONE NUMBER

DO YOU HAVE PRIVATE MEDICAL INSURANCE (OTHER THAN MEDICARE)?

☐ YES ☐ NO IF YES, DESCRIBE.

DID YOU HAVE AN EMERGENCY MEDICAL EXPENSE WITHIN THE LAST THREE MONTHS?

☐ YES ☐ NO IF YES, EXPLAIN.

HAVE YOU HAD AN EYE OPERATION WITHIN THE PAST 12 MONTHS?

☐ YES ☐ NO IF YES, EXPLAIN.

MONTH	AMOUNT	MONTH	AMOUNT	MONTH	AMOUNT
	$		$		$
	$		$		$

SOCIAL SERVICES

	YES	NO
Do you need assistance with your housekeeping and/or personal care?	☐	☐
Do you wish to apply for In–Home Supportive Services?	☐	☐
Do you need mobility and/or daily living skills training from a counselor/teacher for the blind?	☐	☐
Do you wish your Social Worker to review with you the various social service programs for which you may be eligible?	☐	☐

HAVE YOU COMPLETED ALL BOXES?

If you need more room to answer any of these questions, attach a separate sheet of paper.

CERTIFICATION

I HAVE READ AND RECEIVED A COPY OF THE COVERSHEET ATTACHED TO THIS FORM, I AM AWARE OF, UNDERSTAND AND AGREE TO MEET ALL MY RESPONSIBILITIES AS DESCRIBED ON THIS COVERSHEET.

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL AND THAT IF DISSATISFIED I HAVE A RIGHT TO APPEAL.

I REALIZE THAT DELIBERATE MISREPRESENTATION OR CONCEALMENT OF FACTS MAY CONSTITUTE FRAUD FOR WHICH I MAY LOSE MY AID PAYMENTS OR CAN BE PROSECUTED FOR A CRIME.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS OF FACT ARE TRUE AND CORRECT.

SIGNATURE OR MARK (If you use a mark, one witness must sign below)	**DATE**	
SIGNATURE OF WITNESS, INTERPRETER OR PERSON COMPLETING FORM FOR APPLICANT	**TELEPHONE NUMBER**	
ADDRESS	**IS WITNESS NAMED A LEGAL GUARDIAN?** ☐ YES ☐ NO	

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Date Received

Date Filed

EW Signature and Date

Supervisor Signature and Date

DO YOU OR YOUR FAMILY OWN ONE OR MORE VEHICLES?

☐ YES ☐ NO IF YES, EXPLAIN BELOW.

DO YOU HAVE A CURRENT DRIVERS LICENSE?

☐ YES ☐ NO IF YES, LIC. NO.

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MAKE, YEAR, MODEL	OWNER OF VEHICLE	LICENSE FEE	BALANCE OWED
			$
			$

$ _____ Cash Value

$ _____ Cash Value

DO YOU OR YOUR FAMILY HAVE ANY OF THE FOLLOWING INSURANCE COVERAGES? CHECK EACH ITEM. IF YES, EXPLAIN BELOW.

LIFE YES ☐ NO ☐ BURIAL/FUNERAL YES ☐ NO ☐

NAME OF INSURANCE COMPANY	AMOUNT OF INSURANCE	POLICY NUMBER	CASH VALUE	DATE NEEDED
	$		$	
	$		$	
	$		$	

NUMBER OF BURIAL SPACES YOU OWN

$ _____ Total Personal Property

HAVE YOU OR YOUR FAMILY SOLD, TRANSFERRED, OR GIVEN AWAY YOUR OWN HOME, OTHER REAL ESTATE, MONEY OR PERSONAL PROPERTY WITHIN THE PAST TWO YEARS?

☐ YES ☐ NO IF YES, EXPLAIN.

DO YOU OR YOUR SPOUSE OR DEPENDENT CHILD(REN) RECEIVE OR EXPECT TO RECEIVE INCOME FROM ANY OF THE FOLLOWING SOURCES. Check each item. If YES, explain below.

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	YES	NO		YES	NO
A. Social Security Payments	☐	☐	G. Interest Dividends from Stocks, Bonds, Trusts, Oil Leases	☐	☐
B. SSI/SSP Payments	☐	☐	H. Gross Salary, Wages or Commissions	☐	☐
C. Pensions (such as Civil Service Retirement, Railroad Retirement, Union Pensions, etc.)	☐	☐	I. Property Rentals, Leases, Mortgages, or Own Business	☐	☐
D. Unemployment Insurance, Disability Insurance, Workmen's Compensation	☐	☐	J. Regular Cash Contributions	☐	☐
E. Veteran's Benefits	☐	☐	K. Welfare Payments, AFDC General Assistance, etc.	☐	☐
F. G. I. Benefits	☐	☐	L. Other Income (Alimony, Military Allotments, Training Allowances, Alms, etc.)	☐	☐

HAVE YOU APPLIED FOR ANY OF THE ABOVE BENEFITS?	TYPE OF BENEFIT	DATE OF APPLICATION

NAME OF PERSON RECEIVING INCOME	SOURCE OF INCOME	HOW OFTEN RECEIVED	AMOUNT
			$
			$
			$
			$

DO YOU OR YOUR SPOUSE BELIEVE YOU MIGHT BE ELIGIBLE FOR CERTAIN INCOME OR PAYMENTS SUCH AS THOSE ABOVE WHICH YOU ARE NOT NOW RECEIVING?

☐ YES ☐ NO IF YES, EXPLAIN.

STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE – APSB

APPLICANT'S NAME	SOCIAL SECURITY NUMBER *	FOR COUNTY USE ONLY
		District
MAILING ADDRESS	TELEPHONE NUMBER	File Number
		State Number
IN CASE OF EMERGENCY, CONTACT	RELATIONSHIP TO APPLICANT	District Telephone Number
ADDRESS	TELEPHONE NUMBER	Date Sent

APPLICANT'S BIRTHDATE MO. / DAY / YR.	BIRTHPLACE (CITY, STATE)

ARE YOU NOW LIVING IN CALIFORNIA AND INTEND TO CONTINUE LIVING HERE?	ARE YOU A UNITED STATES CITIZEN? IF "NO", WHAT IS YOUR ALIEN REGISTRATION NUMBER?
☐ YES ☐ NO	☐ YES ☐ NO

PRESENT MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NUMBER
☐ SINGLE ☐ SEPARATED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		

NAME OF UNMARRIED DEPENDENT CHILDREN	SOCIAL SECURITY NUMBER *
NAME	SOCIAL SECURITY NUMBER *
NAME	SOCIAL SECURITY NUMBER *
NAME	SOCIAL SECURITY NUMBER *

DO YOU HAVE MEDICARE HOSPITAL COVERAGE?	DO YOU HAVE MEDICARE MAJOR MEDICAL COVERAGE?	RED, WHITE, AND BLUE MEDICARE CARD NUMBER	*FOR COUNTY USE ONLY*
☐ YES ☐ NO	☐ YES ☐ NO		
HAVE YOU OR YOUR SPOUSE, PARENT OR CHILD SERVED IN THE ARMED FORCES? ☐ YES ☐ NO	WHAT BRANCH OF SERVICE?	SELECTIVE SERVICE NUMBER	

ARE YOU CURRENTLY RECEIVING VA BENEFITS?

☐ YES ☐ NO IF YES, THE VA CLAIM NUMBER IS:

DO YOU OR YOUR SPOUSE OWN ALL OR PART OF ANY OF THE FOLLOWING, OTHER THAN THE HOUSE YOU LIVE IN?

CHECK EACH ITEM	YES	NO	ASSESSED VALUE FROM LAST TAX STATEMENT
RENTAL PROPERTY	☐	☐	
OTHER BUILDING	☐	☐	
LAND	☐	☐	

DO YOU OR YOUR SPOUSE HAVE THE FOLLOWING PERSONAL PROPERTY?

CHECK EACH ITEM. IF YES, EXPLAIN BELOW.

	YES	NO		YES	NO
A. SAVINGS ACCOUNT	☐	☐	E. STOCKS OR BONDS	☐	☐
B. CHECKING ACCOUNT	☐	☐	F. MORTGAGES, TRUST DEEDS, SALES CONTRACTS	☐	☐
C. CREDIT UNION OR SAFE DEPOSIT BOX	☐	☐	G. OTHER PERSONAL PROPERTY	☐	☐
D. MONEY ON HAND OR IN THE HOUSE	☐	☐			

TYPE OF PERS. PROPERTY	OWNER	CURRENT VALUE	NAME OF BANK, ETC.	ACCOUNT NUMBER
		$		
		$		
		$		

IMPORTANT INSTRUCTIONS TO APPLICANTS AND RECIPIENTS FOR COMPLETING FORM APSB 201

Form APSB 201 is your statement of facts needed to determine your eligibility for the Aid to the Potentially Self-Supporting Blind (APSB) Program. An additional copy of the APSB 201 is available to you upon request. If you follow these instructions, you will help your county welfare department determine your eligibility promptly.

1. It is not necessary for you to pay anyone to help you fill out this form. You can have your husband (wife), child, or friend help you. If you need additional information on how to complete this form, contact your county welfare department representative.

2. You are asked to provide your Social Security Number on this application form. Social Security Numbers are required in the administration of this assistance program (P.L. 94-455 and EAS 40-105).

3. Each numbered/lettered box must be completed as fully as possible. This is very important because you cannot be granted aid until all applicable questions have been answered completely. Any omission or unanswered questions may seriously delay the determination of your eligibility.

4. Use receipts and records to help you answer questions and be prepared to produce them to support your answers. Use estimates only if you do not have or cannot secure records or receipts.

5. If you do not know the answer to a question, write "Don't Know" in the appropriate space for the answer.

6. You may be prosecuted under penalty of perjury for any deliberate misrepresentation or concealment of facts on this statement.

7. If you need additional space, attach an additional sheet, note the item number and provide the information requested.

STATEMENT OF RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS

You cannot receive APSB and SSI/SSP (sometimes called the gold check) at the same time. If the county welfare department finds you eligible for APSB you must choose between the two programs and notify both the county welfare department and the Social Security Administration of your choice.

You should know that the SSI/SSP Program also has special income and property exemptions for blind persons who have plans for self-support. If you are not receiving SSI/SSP or if you are receiving SSI/SSP but not the special exemptions, you should talk with the local Social Security Administration District Office. The county welfare department will help you select which program best meets your needs.

If you are granted APSB, you are required to notify the county welfare department when there is any change in your household membership, income, your needs, financial circumstances, plan for self-support, or your ability to pursue that plan. You should immediately report the following changes:

If your income, as reported to the welfare department increases, decreases or stops.

If you have expenses which are paid for by someone other than yourself.

If you receive money or property from any source (income tax refunds, retirement contribution refunds, insurance, inheritances, gifts, awards, benefits,etc.).

If you receive, transfer or sell any item of real or personal property; i.e. if someone gives you or your family such things as a car, house, insurance, T.V., refrigerator, etc.;

If you, or your spouse obtain employment/training or are no longer employed or in training;

If you marry or remarry;

If you move or plan to visit outside the county or state for longer than 30 days;

If you change your address.

IF YOU HAVE ANY DOUBT WHETHER YOU ARE REQUIRED TO REPORT A PARTICULAR CHANGE, YOU SHOULD CONTACT YOUR ELIGIBILITY WORKER IMMEDIATELY TO DETERMINE WHETHER THE CHANGE MUST BE REPORTED.

You will be notified, in writing, of the wefare department's decision on your application. If your application is denied, the reasons will be given. If you are dissatisfied with the action, or lack of action by the county welfare department, or feel you have been discriminated against in any way, you have the right to request a fair hearing and a decision by the Director of the Department of Social Services. Your request must be received by the Department of Social Services within 90 days of the postmarked date of the notice of action with which you are dissatisfied. You are entitled to be represented by a person of your own choosing, including legal counsel. A request for a hearing must be submitted in writing to **OFFICE OF THE CHIEF REFEREE, DEPARTMENT OF SOCIAL SERVICES, 744 P STREET, SACRAMENTO, CALIFORNIA 95814.**

I CERTIFY THAT I HAVE INFORMED THE APPLICANT OF THE POSSIBILITY OF CRIMINAL PENALTIES FOR MISREPRESENTATION OR CONCEALMENT OF FACTS WHICH DETERMINE HIS/HER ELIGIBILITY.

Eligibility Worker's Signature | Eligibility Worker's Number | Date

I CERTIFY THAT I AM AWARE OF THE POSSIBILITY OF CRIMINAL PENALTIES FOR MISREPRESENTATION OR CONCEALMENT OF FACTS WHICH DETERMINE MY ELIGIBILITY.

Applicant's Signature | Date