STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-5330

March 6, 1986

ALL-COUNTY INFORMATION NOTICE I-22-86

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: REVISED CA 1 (11/85), APPLICATION FOR PUBLIC ASSISTANCE

This letter provides you with a reproducible English copy of the revised CA 1 (11/85). Copies of the CA 1 in Spanish will follow under separate cover.

The revisions to the CA 1 accomplish the following: (1) combine the Application for Public Assistance (CA 1) and the Immediate Need Determination (CA 4); (2) add a penalty of perjury certification section to eliminate a federal exception issue, and (3) other technical changes to update the form. A list of the changes made to this form is attached. This revision was accomplished with assistance of members of the CWDA Forms Subcommittee and input from welfare rights organizations.

Regular supplies of the CA 1 (11/85) English version are expected to be available during February 1986 from the DSS warehouse. Counties should use the standard GEN 727B ordering procedure to obtain their supplies.

When warehouse supplies of the Spanish CA 1 (11/85) version are available, counties will be notified through the GEN 127 process.

Counties may continue to use up their existing supplies of the CA 1 (5/83) and the CA 4 (7/78) until June 1, 1986, or until supplies are exhausted, whichever occurs first. Also, counties who print their own supplies of the CA 1 may begin use of the 11/85 version upon receipt of this notice. Counties are not to reprint supplies of the CA 1 (5/83) or CA 4 (7/78) versions.

The AFDC and Food Stamps Policy Implementation Bureau (AFPIB) is receptive to any suggestions or recommendations for improving AFDC forms. Should you have any comments on the revised CA 1, you may forward them to AFPIB for consideration during the next revision. If you have any questions regarding the CA 1, please contact Dennis Ragasa of AFPIB at (916) 322-5330.

ROBERT A. HOREL
Deputy Director

Attachment

Attachment

CHANGES TO THE CA 1 (11/85), APPLICATION FOR PUBLIC ASSISTANCE

Front of the CA 1

Question 1

- Added "First, Middle Initial, Last" to Name of Applicant box
- Added "(if applicable)" to Maiden Name box.

Question 2

- Added "EA/(Specify)" and "other (specify)" boxes
- Added a "Do you want to apply for Food Stamps?" question.
- Deleted the emergency situation questions.

Question 3

- Combined the questions concerning where the applicant last applied for or received public assistance.
- Substituted "Cash Aid" for "AFDC"

Question 4

- Added the "Do you have a Personal Emergency?" question with check boxes for medical, child or spousal abuse and other (specify).

Question 5

Immediate Need

- Added 5a which deals with the Immediate Need questions from the old CA 4.
- Added 5b which asks about resources from the old CA 4.

- Added 5c which asks about the receipt or expectation of income or other benefits from the old CA 4.

Question 6

- Relocates the ethnic group and language questions.

Certification Section

- Adds the penalty of perjury under the laws of the State of California statement.
- Deletes the Applicant's Representative boxes.

Back of the CA 1

- Formats the information into two columns.
- Added an "Immediate Need" explanation paragraph.
- Review of Public Assistance Cases - added information concerning the verification of benefit and income information provided by the applicant.
- Resolving Disputes and Complaints - changed the address for filing a state hearing to the applicant's local county welfare department.

APPLICATION FOR PUBLIC ASSISTANCE

COUNTY OF APPLICATION

1. NAME OF APPLICANT (Person for whom assistance is requested)(FIRST, MIDDLE INITIAL, LAST) | MAIDEN NAME (If applicable) | SOCIAL SECURITY NUMBER

STREET ADDRESS | APARTMENT NUMBER

CITY | COUNTY | ZIP CODE | PHONE NUMBER ( )

2. TYPE OF PUBLIC ASSISTANCE FOR WHICH YOU ARE APPLYING (Check appropriate boxes)

☐ Cash Aid ☐ Medi-Cal ☐ EA/(Specify)_____ ☐ Other (Specify)_____

DO YOU WANT TO APPLY FOR FOOD STAMPS? ☐ YES ☐ NO

3. HAVE YOU OR YOUR FAMILY RECEIVED OR APPLIED FOR PUBLIC ASSISTANCE IN THE PAST? ☐ YES ☐ NO
(If "YES", complete the following:)

DATE AND PLACE WHERE LAST APPLIED OR RECEIVED | TYPE OF AID (Cash Aid, Food Stamps, Medi-Cal, etc.) | NAME USED (If different from above)

4. DO YOU HAVE A PERSONAL EMERGENCY? ☐ YES ☐ NO

☐ Medical ☐ Child or Spousal Abuse ☐ Other (Specify)_____

5. a. CASH AID — EMERGENCY SITUATION AND REQUEST FOR ASSISTANCE DUE TO IMMEDIATE NEED.

DO YOU REQUEST IMMEDIATE ASSISTANCE? (See the important information about immediate need on the back of this form.) ☐ YES ☐ NO

IF YOU ARE NOT IN AN EMERGENCY SITUATION, GO TO QUESTION 6. AND COMPLETE THE REST OF THE FORM. IF YOU THINK YOU HAVE AN EMERGENCY, CHECK THE BOX(ES) THAT APPLIES TO YOUR SITUATION AND FILL IN THE INFORMATION ASKED FOR BELOW:

☐ We have no food. ☐ Our food will last for _____ days. (ESTIMATE) ☐ We have no housing.

☐ We cannot pay rent which is due on _____. ☐ We received one of the following and must move by _____.

☐ The following utility(s) was/will be turned off by_____.

☐ Gas ☐ Electricity ☐ Water ☐ Sewage ☐ Notice to Vacate ☐ Notice of Eviction

☐ Other (Specify) _____

5. b. DO YOU HAVE ANY OF THE FOLLOWING RESOURCES? (Check appropriate boxes. If "YES", indicate amount or value of resource.)

	YES	NO	AMOUNT/VALUE		YES	NO	AMOUNT/VALUE		YES	NO	AMOUNT/VALUE
Cash or Checks	☐	☐	$_____	Stocks or Bonds	☐	☐	$_____	Credit Union Account	☐	☐	$_____
Savings or Checking Account	☐	☐	$_____	Trust Fund or Deed	☐	☐	$_____	Other (Specify)	☐	☐	$_____

5. c. HAVE YOU RECEIVED OR DO YOU EXPECT TO RECEIVE INCOME OR OTHER BENEFITS THIS MONTH? ☐ YES ☐ NO
(Examples of income or benefits include wages, loans, vacation or retirement pay, Unemployment Insurance, child support, etc.)
(If "YES", complete the following:)

TYPE OF INCOME OR BENEFITS	AMOUNT	DATE	SOURCE OF INCOME OR BENEFITS
	☐ Received $_____	☐ Received on _____	
	☐ Expected $_____	☐ Expected on _____	

6. The law requires that information on ethnic origin and primary language be collected. However, the information will not affect your eligibility for aid. If you do not complete this section, the Eligibility Worker will make this judgement.

MY ETHNIC GROUP IS (Check one box only):

☐ White ☐ Black (Not of Hispanic origin) ☐ American Indian or Alaskan Native

☐ Hispanic ☐ Asian or Pacific Islander ☐ Filipino

MY LANGUAGE NEED IS (Check one box only):

☐ English ☐ Chinese ☐ Korean ☐ Filipino (Tagalog)

☐ Spanish ☐ Japanese ☐ Vietnamese ☐ Other (Specify)_____

CERTIFICATION

I understand and agree that I have to comply with all eligibility requirements, some of which I may be asked to do before the county issues an immediate need payment, such as: registering for work, furnishing social security numbers, accepting any income which may be available to me, cooperating with the district attorney regarding child support, etc. Also, I understand that the statements I have made on this form are subject to investigation and verification.

I declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct.

SIGNATURE (OR MARK) OF APPLICANT | DATE SIGNED

SIGNATURE OF WITNESS TO MARK (Interpreter, or person completing form for applicant) | DATE SIGNED

READ THE IMPORTANT INFORMATION ON THE BACK OF THIS FORM

IMPORTANT INFORMATION FOR APPLICANTS OF PUBLIC ASSISTANCE PROGRAMS

Below is information about the Public Assistance Program(s) for which you have applied. Please read this information carefully. You may obtain further detailed information about these programs by reading the handbook entitled "AFDC Recipient Handbook" available through the county welfare department.

APPLICATION PROCESSING TIME

The county welfare department is required to either approve or deny your AFDC (Aid to Families with Dependent Children) application within 45 days and your Food Stamp application within 30 days

DOCUMENTATION

You must promptly provide documents (for example: birth certificates, bank books, car registration, pay stubs, documents showing ownership of land, home, etc.) and/or information requested by the county welfare department so they can determine your eligibility for aid. If you don't provide the necessary documents and information your application may be delayed or denied.

WORK REGISTRATION

In order to qualify for Aid to Families with Dependent Children (AFDC) you may be required to register for work and to be available for and seeking work. Your eligibility worker will tell you if you must register. If you are required to do so and you refuse, you will personally be ineligible for aid. In some situations, refusal will make the whole family ineligible.

ELIGIBILITY FOR OTHER INCOME

All AFDC applicants must apply for and accept any income which may be available to them, such as: Unemployment or Disability benefits, Veteran's benefits, Social Security benefits, etc.

MEDICAL COVERAGE

If your application for cash aid is approved, you may be eligible for medical coverage through the "Medi -Cal" Program. The eligibility worker will explain the Medi-Cal program to you.

IMMEDIATE NEED

In order to qualify for immediate need:

- you must have an emergency situation (examples are: lack of food, lack of housing, notice of eviction, notice of termination or loss of utilities).
- your liquid resources must be less than $100 and cannot cover the cost of your emergency.
- you must be apparently eligible for AFDC.

If you have any questions, ask your eligibility worker.

REVIEW OF PUBLIC ASSISTANCE CASES

Federal, state and county representatives periodically review cases to ensure that your eligibility for Public Assistance and the amount of aid you receive have been determined correctly. If your case is selected for review, you will be notified and you must cooperate in this review by providing the requested information and documents. Also, benefit and income information will be regularly requested from the Department of Employment Development, the Internal Revenue Service, the Social Security Administration and other agencies to verify the information that you have reported.

SOCIAL SECURITY NUMBER

You must provide your Social Security Number(s) because the furnishing of the Social Security Number is a condition of eligibility required by Section 402(a)(25) of the Social Security Act. The number will be used in the administration of the AFDC program.

RESOLVING DISPUTES AND COMPLAINTS

If you are dissatisfied with any action or decision that affects your application, you should try to resolve the issue with the county welfare department. If you are unable to resolve the issue, you may file a complaint or request a state hearing through the county welfare department.

For any complaint that you cannot resolve with the county welfare department you may call, write, or go in person to one of the following offices:

Los Angeles — 107 South Broadway, 90012
Phone (213) 620-4385

Sacramento — 744 P Street, 95814
Phone (916) 322-2400

You may also call the following toll free numbers: (800) 952-5253 or **(for the deaf only)** TDD (800) 952-8349 in Sacramento. For both numbers you may have to dial "1" first. You will not have to pay for the call.

For a State Hearing mail your written request to the welfare department in your county.

You must state that you want a hearing and why you are dissatisfied. A request for a hearing must be received by the county welfare department within 90 days of the action with which you are dissatisfied.

COUNTY USE ONLY

CASE NAME	STATE NUMBER COUNTY AID SERIAL NO.	
NAME OF COUNTY WORKER TAKING APPLICATION	DATE	COUNTY

DISPOSITION OF EMERGENCY SITUATION

☐ Immediate need payment issued. Notice of Action provided.

☐ Immediate need payment denied. Notice of Action provided.

☐ Regular AFDC cash aid payment issued. Notice of Action provided.

☐ Concurrent Action Taken:

COMMENTS:

ETHNIC ORIGIN

WH	H	B	A—P
1	2	3	4
A—I	F		
5	7		

PRIMARY LANGUAGE

SP	CH	J	K
1	2	3	4
F	O	E	V
5	6	7	8