

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



January 18, 1991

ALL-COUNTY INFORMATION NO. I-03-91

TO: ALL-COUNTY WELFARE DIRECTORS

SUBJECT: REVISION OF SOC 295, APPLICATION FOR SOCIAL SERVICES

REFERENCE: ACL 90-24, ACIN I-69-89, AND IN-HOME SUPPORTIVE SERVICES CASE MANAGEMENT, INFORMATION AND PAYROLLING SYSTEMS NEWS, RELEASE 11, EDITION 67, FEBRUARY/MARCH 1990.

This ACIN is intended to inform Counties that the SOC 295, Application for Social Services, has been revised as illustrated by the attached draft of the form. It is estimated that the revised form will be available for order in January, 1991.

Once the revised form is available, please use the form immediately and discard copies of the form SOC 295 (10/83) currently in use. This is necessary because of extensive changes to Section 6, ethnic origin and primary language, which have been mandated by State law. The form has been revised to include the complete list of ethnic origin and primary language codes.

The ethnic origin and language codes were distributed to the Counties via ACL No. 90-24, dated March 1, 1990, which identified the need for the new coding for accurate completion of the ABCD 350, Annual Recipient Report on Ethnic Origin and Primary Language. As stated in ACL No. 90-24, the changes to ethnic origin were mandated by Assembly Bill 814 (Chapter 965, Statutes of 1989), which was effective January 1, 1990.

For the In-Home Supportive Services (IHSS) Program, County social service staff were informed of the coding changes for ethnic origin and primary language via IHSS Case Management, Information and Payrolling System (CMIPS) News, Release 11, Edition 67, dated February/March 1990. The CMIPS changes were effective March 7, 1990. Counties were asked to use the new codes with all new applications and, where applicable, to change the code at the time of the next face-to-face visit.

Counties are requested to ensure that all cases are updated with the new ethnic origin and primary language codes by March, 1991, so that the ABCD 350 will reflect accurate IHSS information. This will allow the State Department of Social Services (SDSS) Civil Rights Bureau to assess County compliance with the requirements of Division 21 regulations. The ethnic origin and primary language information will be listed on the CMIPS IHSS Recipient Monthly Characteristics Listing.

If you have questions regarding the revised SOC 295, please contact the Adult Services Branch at (916) 322-6320.

Sincerely,

LOREN D. SUTER
Deputy Director
Adult and Family Services

Attachment

cc: CWDA

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: Please complete Section 1 - 7 on this form. This form is subject to verification.

NOTE: Retain your copy of this application. If you have not received a response within 30 days notify the county representative at the telephone number provided below in the "FOR AGENCY USE ONLY" Section.

* **SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

| | | | |
|--------------|----------|----------------------|--|
| CASE NUMBER: | | DATE OF APPLICATION: | |
| 1. NAME | | | *SOCIAL SECURITY NUMBER |
| ADDRESS | | | SEX <input type="checkbox"/> Male <input type="checkbox"/> Female |
| CITY | ZIP CODE | TELEPHONE () | BIRTHDATE |

| | | |
|---|--|---|
| 2. Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No | ARE YOU A SPOUSE/CHILD OF A VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No | IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER: |
|---|--|---|

| | |
|--|--|
| 3. Do you receive SSI/SSP benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: <input type="checkbox"/> Independent Living <input type="checkbox"/> Board and Care <input type="checkbox"/> Home of Another |
| SERVICES BEING REQUESTED: | |

| | | |
|---|-----------------|-------------------------------------|
| 4. Have you received In-Home Supportive Services (IHSS) in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If "YES", complete the following: | | |
| DATE AND PLACE OF SERVICE LAST RECEIVED | NUMBER OF HOURS | NAME USED (IF DIFFERENT FROM ABOVE) |

| 5. LIST FAMILY MEMBERS IN HOUSEHOLD | BIRTHDATE | *SOCIAL SECURITY NUMBER |
|---|-----------|-------------------------|
| NAME OF SPOUSE <input type="checkbox"/> NAME OF PARENT <input type="checkbox"/> | | |
| CHILD/OTHER RELATIVE | | |
| CHILD/OTHER RELATIVE | | |

| | |
|---|--|
| 6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service. | |
| A. My ethnic origin is (see reverse side for correct code): <input type="checkbox"/> | B. I speak and understand English: My primary language is (see reverse side for correct code:): <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|--|---|--|------|
| 7. I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future. | | | |
| SIGNATURE OF APPLICANT: | DATE: | SIGNATURE OF APPLICANT'S REPRESENTATIVE: | DATE |
| REPRESENTATIVE'S ADDRESS | REPRESENTATIVE'S TELEPHONE NUMBER: () | RELATIONSHIP TO APPLICANT: | |

FOR AGENCY USE ONLY

| | | | | |
|--|--|---------------|--|--------------------------|
| INCOME ELIGIBLE: <input type="checkbox"/> Yes <input type="checkbox"/> No | STATUS ELIGIBLE: <input type="checkbox"/> Yes <input type="checkbox"/> No | VERIFICATION: | SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE: | TELEPHONE NUMBER: () |
| RECIPIENT STATUS: <input type="checkbox"/> Refugee <input type="checkbox"/> Cuban/Haitian Entrant | SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS (EXPLAIN) | | | |

RECERTIFICATION OF ELIGIBILITY FOR SERVICES OF STATUS ELIGIBLES

| DATE | SOURCE OF VERIFICATION | WORKER SIGNATURE | DATE | SOURCE OF VERIFICATION | WORKER SIGNATURE |
|------|------------------------|------------------|------|------------------------|------------------|
| | | | | | |
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A. Ethnic Codes:

1. White
2. Hispanic
3. Black
4. Other Asian or Pacific Islander
5. American Indian or Alaskan Native
7. Filipino
- C. Chinese
- H. Cambodian
- J. Japanese
- K. Korean
- M. Samoan
- N. Asian Indian
- P. Hawaiian
- R. Guamanian
- T. Laotian
- V. Vietnamese

B. Language Codes:

- | | |
|--|---------------|
| O. American Sign Language (AMISLAN or ASL) | G. Mien |
| 1. Spanish - NOA will be issued in Spanish | H. Hmong |
| 2. Cantonese | I. Lao |
| 3. Japanese | J. Turkish |
| 4. Korean | K. Hebrew |
| 5. Tagalog | L. French |
| 6. Other non-English | M. Polish |
| 7. English | N. Russian |
| 9. Spanish - NOA will be issued in English | P. Portuguese |
| A. Other Sign Language | Q. Italian |
| B. Mandarin | R. Arabic |
| C. Other Chinese Languages | S. Samoan |
| D. Cambodian | T. Thai |
| E. Armenian | U. Farsi |
| F. Ilacano | V. Vietnamese |