

## DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



October 31, 1995

ALL-COUNTY INFORMATION NOTICE NO.  
I-52-95

TO: ALL COUNTY WELFARE DIRECTORS

## REASON FOR THIS TRANSMITTAL

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

SUBJECT: Revisions Of Forms: DFA 285B, Food Stamp Budget Worksheet (Rev.9/95); DFA 285C, Application for Special Medical Deductions (Rev.9/95); DFA 285D, Food Stamp Budget Worksheet--Special Medical/Shelter Deductions (Rev.9/95); DFA 377.5, Food Stamp Household Change Report (Rev.10/95)

REFERENCE: ALL COUNTY LETTER # 94-67, ALL COUNTY LETTER # 95-49,  
ALL COUNTY LETTER # 95-57

This notice transmits copies of the revised forms DFA 285B, DFA 285C, DFA 285D, and DFA 377.5. The forms reflect changes from several regulation packages, including the dependent care deduction portion of the Mickey Leland package, the changes in reporting of child support paid by the household, the changes in reporting of medical expense deductions for households with elderly or disabled members, and changes which will be implemented with the first phase of the SB 35 Compatibility regulations. The SB 35 changes will be made in the near future and you will receive further written instructions when they are to be implemented.

The specific changes for each form are outlined below:

DFA 285B, Food Stamp Budget Worksheet

Section G, Dependent Care

A second line was added to this section, so that separate lines for children under the age of two, children over the age of two/or all others, and the total dependent care amount could be given.

Section H, Child Support Paid Out

This section was added to reflect the new regulations which became effective October 1, 1995.

Sections I-K were relettered.

Part 4--Section L, Motor Vehicles

The additional exclusion of a vehicle, when it is used to transport the primary source of fuel for heating or water for home use, is reflected in the exclusions listed.

The vehicle section has been revised and reformatted to reflect the changes which will be made as part of the implementation of SB 35 Compatibility, Phase 1. Counties will be sent implementation instructions under separate cover at a future date.

The amount excluded when computing the value of the vehicle, which used to be \$4550 and is now \$4600, fluctuates. Therefore, the amount has been left blank and the worker should enter the correct amount when computing the vehicle value.

Section M was relettered.

Section N, Self-Employment Expenses

The anticipated changes in the allowed expenses, which will be implemented by SB 35 Compatibility Phase 1, are given on line 2. The implementation instructions will be sent under separate cover at a future date.

Section O was relettered.

DFA 285C Food Stamp Application for Special Medical Deductions

Part 2

The format of the entire section was changed. The last column is now checked yes if a non-household source is responsible for payment of the expense. Additionally, item (g.) was reworded regarding service animals, with examples of what service animals are given. The examples are not meant to limit the scope of service animals.

Under the penalty warning section, the maximum fines and/or sentences in jail has been updated to \$250,000 and 20 years.

DFA 285D Food Stamp Budget Worksheet--Special Medical/Shelter Deductions

Section D, Excess Medical Expenses

Lines 1 and 2 have been reworded and now include averaged expenses in each of the two categories.

Section E, Standard/Dependent Care Deduction/Medical Deductions

See changes for DFA 285B, section G.

Section F, Child Support Deduction

This section was added to reflect the new regulations which became effective October 1, 1995.

See changes for DFA 285B, section H.

Sections G through I have been relettered.

Part 4--Section K, Motor Vehicles

See DFA 285B, Part 4, section L.

Part 5--Section M, Self-Employment

See DFA 285B, Part 5, section N.

DFA 377.5 Food Stamp Household Change Report

The entire section for question number 4 was reworded to be consistent with the Medical Deduction changes effective November 1, 1995.

Question number 7 was added for the household to report payment of Child Support by a household member or changes in the amount of child support paid by a household member.

Questions 8 and 9 were renumbered.

Certification Section

The information regarding the maximum fines and jail sentences that can be imposed for fraud has been updated to \$250,000 and 20 years.

STOCK

The California Department of Social Services' (CDSS) warehouse will no longer stock the previous versions of these forms and all old stock will be destroyed. Counties should also destroy any supplies they may have of older versions of the forms and begin using the new versions when the forms are available from the warehouse. CWDs may order stock from the warehouse according to the normal procedures contained in the County Forms Catalog. CWDs which wish to print their own forms may obtain camera-ready copies of these forms by contacting the CDSS Forms Management Unit at (916) 657-1907 or CALNET 437-1907.

TRANSLATIONS

Counties that need a camera-ready copy of the forms DFA 285C and DFA 377.5 should call:

For English and Spanish: the Forms Management Bureau at (916) 657-1907 or CALNET 437-1984.

For the Asian language versions (Chinese, Cambodian, and Vietnamese): the Language Services Bureau at (916) 654-1305 and CALNET 464-1305. These translations will be forwarded to the County Forms Coordinator when they are available.

If you have any questions regarding the forms changes, please call Melissa Buchanan of the Food Stamp Program Bureau at (916) 654-8567.

  
BRUCE WAGSTAFF  
Deputy Director  
Welfare Programs Division

Attachments

c: CWDA

# FOOD STAMP BUDGET WORKSHEET

<b>CASE NAME</b>	<b>CASE NUMBER</b>	<b>COMPANION CASE REFERENCE</b>		<b>CLASSIFICATION</b> <input type="checkbox"/> NA <input type="checkbox"/> PA <input type="checkbox"/> MIXED
<b>CERTIFICATION PERIOD</b> FROM _____ THROUGH _____	<b>ISSUANCE MONTH</b>	<b>ISSUANCE MONTH</b>		<b>DOCUMENTATION</b>
<b>PART 1 - GROSS INCOME ELIGIBILITY</b>				
<b>A. NONEXEMPT GROSS EARNED INCOME</b>				
1. Gross Salary, Wages	\$ _____	\$ _____		
2. Self-Employment	_____	_____		
3. Training Allowance	_____	_____		
4. Total Gross Earned Income (A1 + A2 + A3)	\$ _____	\$ _____		
<b>B. NONEXEMPT GROSS UNEARNED INCOME</b>				
1. Cash Aid	\$ _____	\$ _____		
2. Social Security, UIB, DIB, Pensions	_____	_____		
3. Child/Spousal Support	_____	_____		
4. Scholarships, Grants, Loans	_____	_____		
5. Other	_____	_____		
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)	\$ _____	\$ _____		
<b>C. GROSS INCOME TEST</b>				
1. Household Size	_____	_____		
2. Maximum Gross Income Allowed (from Table)	\$ _____	\$ _____		
3. Total Gross Monthly Income (A4 + B6)	\$ _____	\$ _____		
4. Gross Income Eligible? (Is C3 less than or equal to C2?)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>PART 2 - NET INCOME ELIGIBILITY</b>	<input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective		<input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective	
<b>D. INCOME (For Prospective Budgets Only)</b>				
1. Adjusted Gross Earned Income (80% of A4)	\$ _____	\$ _____		
2. Total Nonexempt Gross Income (B6 + D1)	\$ _____	\$ _____		
<b>E. NONEXEMPT GROSS EARNED INCOME (For Retrospective Budgets Only)</b>				
1. Gross Salary, Wages	\$ _____	\$ _____		
2. Self-employment	_____	_____		
3. Training Allowance	_____	_____		
4. Total Gross Earned Income (E1 + E2 + E3)	\$ _____	\$ _____		
5. Adjusted Gross Earned Income (80% of E4)	\$ _____	\$ _____		
<b>F. NONEXEMPT GROSS UNEARNED INCOME (For Retrospective Budgets Only)</b>				
1. Cash Aid	\$ _____	\$ _____		
2. Social Security, UIB, DIB, Pensions	_____	_____		
3. Child/Spousal Support	_____	_____		
4. Scholarships, Grants, Loans	_____	_____		
5. Other	_____	_____		
6. Total Gross Unearned Income (F1 + F2 + F3 + F4 + F5)	\$ _____	\$ _____		
7. Total nonexempt Gross Income (E5 + F6)	\$ _____	\$ _____		
<b>G. STANDARD/DEPENDENT CARE DEDUCTION</b>				
1. Standard Deduction:	\$ _____	\$ _____		
2. Dependent Care (Lesser of Actual or Maximum)	_____	_____		
Child(ren) under two	_____	_____		
Child(ren) two and over/all other dependents	_____	_____		
Total Dependent Deductions	\$ _____	\$ _____		
3. Total Deductions (G1 + G2)	\$ _____	\$ _____		
4. Preliminary Adjusted Income (D2 - G3 or F7 - G3)	\$ _____	\$ _____		
<b>H. CHILD SUPPORT DEDUCTION</b>				
1. Total Legally Obligated Child Support paid out by household	\$ _____	\$ _____		
2. Adjusted Income (G4 - H1)	\$ _____	\$ _____		
<b>I. SHELTER DEDUCTION</b>				
1. Total Housing Costs	\$ _____	\$ _____		
2. Total Utility costs (Actual or SUA)	_____	_____		
3. Total Shelter Costs	\$ _____	\$ _____		
4. Allowable Shelter Costs (50% of H2)	\$ _____	\$ _____		
5. Excess shelter Costs (I3 - I4)	\$ _____	\$ _____		
6. Maximum Allowance for Shelter	\$ _____	\$ _____		
7. Allowable Shelter Deduction (Lesser of I5 or I6)	\$ _____	\$ _____		
<b>J. NET MONTHLY INCOME (H2 - I7)</b>	\$ _____	\$ _____		
<b>K. NET INCOME TEST</b>				
1. Household Size	_____	_____		
2. Maximum Net Income Allowable from	_____	_____		
3. Net Income eligible	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>PART 3 - BENEFITS</b>	<b>Allotment</b>	<b>Supplement</b>	<b>Allotment</b>	<b>Supplement</b>
E.W. Initials/Date				

**WORKSHEET FOR CHANGES AND OTHER DOCUMENTATION**

**PART 4-RESOURCES**

**L. MOTOR VEHICLES**

	Vehicle 1	Vehicle 2
1. Vehicle Owner		
Year/Class		
Make and Model		
Estimated Value		
Amount Owed		
Licensed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Value		
3. Excluded as home, income producing, transport for handicapped or primary transport for fuel or water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Under current exclusion limit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Exempt for household use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. For work, to seek work, school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**DOCUMENTATION**

For one licensed vehicle per household, determine the equity value; subtract the exclusion limit & apply the excess to the resource limit. Apply the full equity value of all other vehicles to the resource limit.

If applicant/recipient disagrees with excess value of vehicle document below the alternate method used to determine value.

FMV	
Minus Encumbrance	
Equity Value	
Equity Value	
Minus Exclusion Limit	
Excess Value	

If exempt and under exclusion limit, STOP here

**M. RESOURCE ELIGIBILITY (Nonexempt Resources Only)**

1. Previous Month's Resources
2. Additional Resources (specify)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
3. Subtotal (J1 + J2a + J2b + J2c)
4. Resources Sold, Traded or Given Away (specify)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
5. Subtotal (J4a + J4b + J4c)
6. Current Resources (J3 - J5)
7. Resource Eligible?

	ISSUANCE MONTH	ISSUANCE MONTH
\$ _____		\$ _____
_____		_____
_____		_____
\$ _____		\$ _____
\$ _____		\$ _____
\$ _____		\$ _____
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART 5-INCOME COMPUTATIONS**

**N. SELF-EMPLOYMENT (Nonexempt Resources Only)**

1. Gross Income from Self-Employment
2. Expenses:  Standard 40% Deduction  
 Actual Expenses (Verification Required)
3. Total Nonexempt Income from Self-Employment  
If averaging self-employment income go to K7. If adjusting a previous average, continue to K4.
4. Adjustment to Gross Income
5. Adjustment to Expenses
6. Adjusted Self-Employment Income (K3 + K4 ± K5)
7. Monthly Self-Employment Income (K3 or K6 ÷ number of months income covers)

	ISSUANCE MONTH	ISSUANCE MONTH
\$ _____		\$ _____
_____		_____
\$ _____		\$ _____
\$ _____		\$ _____
\$ _____		\$ _____

**O. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS**

1. Income from Grants, Scholarships or Loans
2. Tuition and Mandatory Fees
3. Total Nonexempt Educational Income (L1 - L2)
4. Monthly Income from Grants, Scholarships or Loans (L3 ÷ number of months income covers)

	ISSUANCE MONTH	ISSUANCE MONTH
\$ _____		\$ _____
_____		_____
\$ _____		\$ _____
\$ _____		\$ _____

**PART 6-REPORTED CHANGES (Other than the CA 7 or DFA 377.5)**

Type of Change				
Date Change Occurred				
Date Change Reported				
EW Initials				

# FOOD STAMP SUPPLEMENTAL APPLICATION FOR SPECIAL MEDICAL DEDUCTIONS

**INSTRUCTIONS** – The application is for special medical deductions for any food stamp household member who is elderly or disabled. See the other side of this page for what we mean when we say “elderly or disabled.” DON'T list spouses or children receiving dependent payments from the Social Security Administration (SSA), Veterans Administration (VA), etc.

FOR COUNTY USE ONLY

CASE NAME

1	NAME	BIRTHDATE	TYPE OF BENEFIT RECEIVED (SUCH AS SSA, VA, RAILROAD, ETC.)	MEDICAL PROBLEM OR CONDITION NEEDING CARE
		/ /		
		/ /		
		/ /		

### MEDICAL EXPENSES

2 Give the following information for ONLY person listed above. List all expenses you expect to have during the certification period. Base your estimate on current medical expenses. Attach bills or proof of expenses you have had for the above listed member(s) of the household.

MEDICAL EXPENSE ITEM	HOUSEHOLD MEMBERS RECEIVING SERVICE	TOTAL MEDICAL EXPENSE	TOTAL MONTHLY EXPENSE	WILL NON-HOUSEHOLD SOURCE BE RESPONSIBLE FOR PAYMENT? (i.e., MEDI-CAL, INSURANCE, ETC.)
a. Medical or dental care provided by a certified practitioner				<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Hospitalization or outpatient treatment and nursing care.				<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Prescribed drugs.				<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Health and hospitalization insurance policy premiums.				<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Medicare premiums: Medi-Cal share of costs and/or spend down expenses.				<input type="checkbox"/> YES <input type="checkbox"/> NO
f. Dentures, hearing aids and prosthetics. Prescribed medical supplies and equipment.				<input type="checkbox"/> YES <input type="checkbox"/> NO
g. Service animal (i.e. seeing eye or hearing dog) expenses, including the costs of food and veterinarian bills.				<input type="checkbox"/> YES <input type="checkbox"/> NO
h. Eye glasses and contact lenses prescribed by a physician or optometrist.				<input type="checkbox"/> YES <input type="checkbox"/> NO
i. Cost of transportation and lodging to obtain medical treatment or services.				<input type="checkbox"/> YES <input type="checkbox"/> NO
j. Maintaining an attendant necessary due to age, illness or infirmity.				<input type="checkbox"/> YES <input type="checkbox"/> NO
k. The number and cost of meals furnished to an attendant.				<input type="checkbox"/> YES <input type="checkbox"/> NO
l. Other (specify).				<input type="checkbox"/> YES <input type="checkbox"/> NO

### PENALTY WARNING

You or anyone in the household who gives wrong information on purpose can be prosecuted with penalties of a fine, jail, or both. The penalties can result in disqualification from the Program, fines up to \$250,000 or going to jail for up to 20 years. The disqualification penalties are 5 months for the first violation, 12 months for the second violation, and permanent disqualification for the third violation.

I certify that I understand the questions on this form. I also understand that (1) the information I have given will be checked and verified by local, state, and federal personnel; (2) the household, any adult member (even if they move out), the sponsor of an alien household member or the authorized representative of residents in an eligible institution may be required to repay extra benefits the household should not have received even if it is the county's fault; and (3) that I will give the county proof of my expenses or the name of a person or organization the county may contact to get the proof if I can not get it myself.

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 application is true, correct, and complete.

SIGNATURE (ADULT HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE)		DATE
WITNESS, IF YOU SIGNED WITH AN X	DATE	SIGNATURE OF INTERVIEWING WORKER
		DATE

The application for special medical deductions is for any food stamp household member who is elderly or disabled.

When we say "elderly" we mean anyone who is age 60 or older.

When we say "disabled" we mean anyone who is getting:

- (1) disability payments from the Social Security Administration (SSA) (other than Supplemental Security Income/State Supplementary Program (SSI/SSP)) or the Veterans Administration (VA); OR
- (2) disability retirement benefits from a federal, state or local governmental agency or the Railroad Retirement Board; OR
- (3) Medi-Cal services because of a disability; OR
- (4) interim assistance/emergency general relief while waiting to get SSI/SSP because of a disability **approved** by the Social Security Administration.

**FOOD STAMP BUDGET WORKSHEET - Special Medical/Shelter Deductions**

CASE NAME	CASE NUMBER	COMPANION CASE REFERENCE	CLASSIFICATION <input type="checkbox"/> NA <input type="checkbox"/> PA <input type="checkbox"/> MIXED
CERTIFICATION PERIOD FROM THROUGH	<input type="checkbox"/> PROSPECTIVE <input type="checkbox"/> RETROSPECTIVE	<input type="checkbox"/> PROSPECTIVE <input type="checkbox"/> RETROSPECTIVE	<b>DOCUMENTATION</b>
<b>PART 1 - NET MONTHLY INCOME</b>			
	ISSUANCE MONTH	ISSUANCE MONTH	
<b>A. NONEXEMPT GROSS EARNED INCOME</b>			
1. Gross Salary, Wages	\$ _____	\$ _____	
2. Self-Employment	_____	_____	
3. Training Allowance	_____	_____	
4. Total Gross Earned Income (A1 + A2 + A3)	\$ _____	\$ _____	
5. Adjusted Gross Earned Income (80% of A4)	\$ _____	\$ _____	
<b>B. NONEXEMPT GROSS UNEARNED INCOME</b>			
1. Cash Aid	\$ _____	\$ _____	
2. Social Security, UIB, DIB, Pensions	_____	_____	
3. Child/Spousal Support	_____	_____	
4. Scholarships, Grants, Loans	_____	_____	
5. Other	_____	_____	
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)	\$ _____	\$ _____	
<b>C. TOTAL NONEXEMPT GROSS INCOME (A5 + B6)</b>	\$ _____	\$ _____	
<b>D. EXCESS MEDICAL EXPENSES</b>			
1. Expected Recurring Expenses (occurring during the entire certification period). Include recurring averaged expenses.	\$ _____	\$ _____	
2. Limited Period Expenses (occurring during only a portion of the certification period). Include limited averaged expenses	_____	_____	
3. Total Allowable Expenses (D1 + D2)	\$ _____	\$ _____	
4. Less Medical Expense Allowance (\$35)	\$ _____	\$ _____	
5. Excess Medical Expenses (D3 - D4)	\$ _____	\$ _____	
<b>E. STANDARD/DEPENDENT CARE DEDUCTION/MEDICAL DEDUCTIONS</b>			
1. Standard Deduction	\$ _____	\$ _____	
2. Dependent Care (Lesser of Actual or Maximum) Child(ren) under two Child(ren) two and over/all other dependents Total Dependent Deductions	\$ _____	\$ _____	
3. Excess Medical Expenses (From D5)	\$ _____	\$ _____	
4. Total Deductions (E1 + E2 + E3)	\$ _____	\$ _____	
5. Total Adjusted Income (C - E4)	\$ _____	\$ _____	
<b>F. CHILD SUPPORT DEDUCTION</b>			
1. Total Legally Obligated Child Support paid out by household	\$ _____	\$ _____	
2. Total Adjusted Income (E5 - F1)	\$ _____	\$ _____	
<b>G. SHELTER DEDUCTION</b>			
1. Total Housing Costs	\$ _____	\$ _____	
2. Total Utility Costs (Actual or SUA)	\$ _____	\$ _____	
3. Total Shelter costs	\$ _____	\$ _____	
4. Allowable Shelter Costs (50% of E5)	\$ _____	\$ _____	
5. Excess Shelter Costs G3-G4	\$ _____	\$ _____	
<b>H. NET MONTHLY INCOME (F2-G5)</b>	\$ <span style="border: 1px solid black; display: inline-block; width: 100px; height: 20px;"></span>	\$ <span style="border: 1px solid black; display: inline-block; width: 100px; height: 20px;"></span>	
<b>PART 2 - NET INCOME ELIGIBILITY</b>			
<b>I. NET INCOME TEST</b>			
1. Household Size	_____	\$ _____	
2. Maximum Net Income Allowed (From Table)	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Net Income Eligible? (Is G less than or equal t H2?)	<input type="checkbox"/> Yes <input type="checkbox"/> No		First-Month Benefits Prorated? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PART 3 - BENEFITS</b>	ALLOTMENT	SUPPLEMENT	ALLOTMENT
E.W. Initials/Date			

**WORKSHEET FOR CHANGES AND OTHER DOCUMENTATION**

**PART 4-RESOURCES**

**K. MOTOR VEHICLES**

	Vehicle 1	Vehicle 2
1. Vehicle Owner		
Year/Class		
Make and Model		
Estimated Value		
Amount Owed		
Licensed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Value		
3. Excluded as home, income producing, transport for handicapped or primary transport for fuel or water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Under current exclusion limit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Exempt for household use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. For work, to seek work, school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

DOCUMENTATION	
For one licensed vehicle per household, determine the equity value; subtract exclusion limit & apply the excess to the resource limit. Apply the full equity value of all other vehicles to the resource limit.	If applicant/recipient disagrees with excess value of vehicle document below the alternate method used to determine value.
	FMV
	Minus Encumbrance
	Equity Value
	Equity Value
	Minus Exclusion Limit
Excess Value	

If exempt and under exclusion limit, STOP here

**L. RESOURCE ELIGIBILITY (Nonexempt Resources Only)**

1. Previous Month's Resources
2. Additional Resources (specify)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
3. Subtotal (J1 + J2a + J2b + J2c)
4. Resources Sold, Traded or Given Away (specify)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
5. Subtotal (J4a + J4b + J4c)
6. Current Resources (J3 - J5)
7. Resource Eligible?

ISSUANCE MONTH	ISSUANCE MONTH
\$ _____	\$ _____
_____	_____
_____	_____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART 5-INCOME COMPUTATIONS**

**M. SELF-EMPLOYMENT (Nonexempt Resources Only)**

1. Gross Income from Self-Employment
2. Expenses:  Standard 40% Deduction  
 Actual Expenses (Verification Required)
3. Total Nonexempt Income from Self-Employment  
If averaging self-employment income go to K7. If adjusting a previous average, continue to K4.
4. Adjustment to Gross Income
5. Adjustment to Expenses
6. Adjusted Self-Employment Income (K3 ± K4 ± K5)
7. Monthly Self-Employment Income (K3 or K6 ÷ number of months income covers)

ISSUANCE MONTH	ISSUANCE MONTH
\$ _____	\$ _____
_____	_____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

**N. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS**

1. Income from Grants, Scholarships or Loans
2. Tuition and Mandatory Fees
3. Total Nonexempt Educational Income (L1 - L2)
4. Monthly Income from Grants, Scholarships or Loans (L3 ÷ number of months income covers)

ISSUANCE MONTH	ISSUANCE MONTH
\$ _____	\$ _____
_____	_____
\$ _____	\$ _____
\$ _____	\$ _____

**PART 6-REPORTED CHANGES (Other than the CA 7 or DFA 377.5)**

Type of Change					
Date Change Occurred					
Date Change Reported					
EW Initials					

**FOOD STAMP HOUSEHOLD CHANGE REPORT (DFA 377.5)****INSTRUCTIONS:**

You must report changes within 10 days of the time you learn of any change.  
 You may report changes on this form, in person, or by calling the number below.  
 If you use this form, only complete the sections that apply to the change(s) you are reporting.  
 If you have any questions about what changes you must report, ask your worker.

Worker:

Phone:

**① INCOME CHANGES**

A. Did your household's total income go up or down by more than \$25, such as: you got \$250 last month and you got \$270 this month.  YES

If YES, complete ①C below.

B. Did the source of income for any household member change or did anyone get income from a new source?  YES

If YES, complete ①C below.

C. If YES to ①A or ①B above, enter all income of your household. Attach paystubs or other proof of earnings. For all other income attach proof when a change is reported. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

Name	Source (If Earnings, List Name of Employer)	Amount (Before Deductions)	How Often Received?	Date of Change

**② HOUSEHOLD COMPOSITION CHANGES**

Change	YES	Date of Change	If YES, give name of person, relationship and explain change.
A. Did anyone move into your home, including a newborn?			
B. Did anyone move out of your home or die?			
C. Did you move in with someone else?			
D. Did anyone get married?			
E. Did anyone become disabled or recover from a disability?			
F. Did anyone turn age 60?			
G. Did anyone get a new Social Security Number?* If YES, attach proof.			

**③ RESOURCE CHANGES** YES

A. Did anyone buy or get a licensed vehicle? If YES, complete below:

Vehicle Owner	Year and Class	Make and Model	Estimated Value	Amount Owed
			\$	\$

B. Did the total of your household's cash on hand, money in checking and/or savings account, stocks, bonds, etc., reach or exceed \$2000 or \$3000 for a household that has a member who is age 60 or older?  YES  
 If YES, complete section below:

List Each Item	Amount	Date of Change
	\$	
	\$	
	\$	

**④ MEDICAL EXPENSES (FOR A HOUSEHOLD MEMBER WHO IS DISABLED OR AGE 60 OR OLDER)** YES

Does any household member who is disabled or age 60 or over have new or changed medical expenses of more than \$25, to report?  
 If YES, you may report these expenses and it may increase your allotment once they are verified. Attach proof and complete below.

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense/	Type of Expense	Amount

\* Providing a Social Security Number (SSN) is required by 7 U.S. Code Section 2025E. Anyone who refuses to provide an SSN will be disqualified from receiving food stamps. The SSNs will be used to check identity, to prevent duplicate participation and to verify eligibility and benefits. The SSNs will be used in a computed 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. Fraudulent participation in the Food Stamp Program may result in criminal or civil action or administrative claims.

**5 ADDRESS AND SHELTER COST CHANGES**

- A. Do you have a new mailing address or phone number or do you plan to move? If YES, complete 5 C, 5 D and 5 E.  
 B. Did you move? If YES, complete 5 C, 5 D and 5 E.  
 C. Does someone else live at this address? If YES, give name(s) and relationship: \_\_\_\_\_  
 D. Enter you new address and/or phone number below and enter the date of the change here: \_\_\_\_\_

YES  
 YES  
 YES

Home Address (Number and Street)			Mailing Address (If Different)(Number and Street)		
City	Zip code	Home Phone	City	Zip code	Message Phone

E. Did your housing or utility costs change when you moved? If YES, complete 1, 2 and 3 below:  YES

1. Enter the amount of each housing cost you have and attach bills for each cost. →  
 2. If you claim actual utility costs, enter the amount of each utility cost you have and attach bills for each cost. →

If you claim the standard utility allowance (SUA), attach bills for gas, electricity or other heating fuel.

Rent or Mortgage: \$		Property Taxes or Insurance: \$ (If not in mortgage)	
Utility	Amount	Utility	Amount
Gas or Fuel	\$	Garbage or Trash	\$
Electricity	\$	Water	\$
Telephone	\$	Sewage	\$
Utility Installation	\$	Other(specify)	\$

3. Did anyone not part of your Food Stamp household help you pay any of your housing or utility costs? If YES, complete 3a, b and c.  YES  
 a. Enter the total housing costs paid by the Food Stamp household: \$ \_\_\_\_\_  
 b. Enter the total utility costs paid by the Food Stamp household: \$ \_\_\_\_\_  
 c. Give the name of each person who paid any of the costs, and if they paid housing and/or utility costs:

**6 DEPENDENT CARE EXPENSE CHANGES**

Did you begin getting bills or has there been a change in the amount of your bills for the care of a child or other dependent so that someone in the home could go to work, training or look for a job?  YES

If YES, complete section below and attach a receipt.

Who Received Care?	Cost of Care	Why Care Was Needed	Who Received Care?	Cost of Care	Why Care Was Needed
1.			2.		

**7 CHILD SUPPORT PAID BY HOUSEHOLD**

Has any member of the food stamp household paid legally obligated child support for children not living in the home or with the household? Attach proof of the court order or administrative order showing the requirement to pay the child support and give the amount paid. If there has been a change in the amount of the legally obligated support, Attach proof of the change.  YES

WHO PAID CHILD SUPPORT	PAID TO WHOM	AMOUNT PAID	DATE PAID

**8 DISQUALIFIED INDIVIDUALS/INELIGIBLE ALIENS**

Did any person living in you home who is an ineligible alien or who has been disqualified from the Food Stamp Program have any of the changes in questions 1 through 6?  YES

If YES, give the name of the person and the date of the change, and explain the change below.

**9 OTHER CHANGES/TEMPORARY CHANGES**

Do you have any other changes to report or do you think of the changes in questions 1 through 6 are temporary?  YES  
 If YES, explain

**CERTIFICATION**

- I understand that failing to report information or intentional misrepresentation of facts can result in legal prosecution with penalties of a fine, imprisonment or both. The penalties can result in disqualification from Program, fine up to \$250,000 and imprisonment up to 20 years. The disqualification penalties are 6 month for the first violation, 12 months for the second violation, and permanent disqualification for the third violation.
- I understand that I have only 10 days to tell my worker about changes in my household.
- I understand that the facts I have reported will be matched and verified by local, state and federal staff.
- I understand that the household, any adult member (even if they move out), the sponsor of an alien household member, or the authorized representative of residents in an eligible institution may be required to repay extra benefits the household should not have received, even if it's the County's fault.
- I understand that I have the right to ask for a state hearing on any action by the County Welfare Department.
- I declare that the facts contained in this report are true, correct and complete.

SIGNATURE (HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (WITNESS, IF YOU SIGNED WITH AN X)	DATE