

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, Sacramento, CA 95814



January 8, 2003

ALL-COUNTY LETTER NO. 03-02

TO: ALL-COUNTY WELFARE DIRECTORS  
ALL CAPI PROGRAM MANAGERS

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: NEW APPLICATION FORMS FOR THE CASH ASSISTANCE PROGRAM FOR IMMIGRANTS

REFERENCE: ALL-COUNTY LETTER 98-92

The purpose of this All-County Letter (ACL) is to advise counties that there are new or revised Cash Assistance Program for Immigrants (CAPI) forms that are required to establish initial CAPI eligibility.

**BACKGROUND**

ACL 98-92 required four different forms to be used in the CAPI application process:

- SAWS 1/CA 1 APPLICATION FOR CASH AID FOOD STAMPS, AND/OR MEDI-CAL/STATES CMSP(CW1)
- MC 210 STATEMENT OF FACTS (MEDI-CAL)
- SOC 451 CAPI SUPPLEMENTAL APPLICATION
- SOC 453 STATEMENT OF LIVING ARRANGEMENT AND HOUSEHOLD EXPENSES

The MC 210 was chosen partly for the county's convenience, and partly for expediency, since CAPI was initially scheduled to be just a temporary program. CAPI is now permanent and State law requires CAPI to mirror the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program. Some questions on the MC 210 are not applicable to CAPI, and other questions asked on the SSI/SSP application are not asked on the MC 210. It was also reported that the use of the Medi-Cal form (MC 210) in the CAPI application process and the previous SOC 453 sometimes caused confusion for the CAPI applicants. The SOC 451 form did not solicit all the information needed regarding an applicant's sponsor. Consequently, the MC 210 has been replaced in the CAPI application process, and the SOC 451 and SOC 453 forms have been revised. County representatives from the CAPI workgroup led the sub-committee responsible for the design and revision of the forms included in this ACL.

## NEW AND REVISED CAPI APPLICATION FORMS

Listed below are the old, new and revised forms to be used in the CAPI application process.

- SAWS 1/CA 1 APPLICATION FOR CASH AID FOOD STAMPS, AND/OR MEDI-CAL/STATES CMSP(CW1)

There is no change in this form or in its use in the CAPI application process.

- SOC 814 (11/02 version) STATEMENT OF FACTS CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)

This form replaces the MC 210 and much of the previous SOC 451. The SOC 814 was patterned after the SSI/SSP application form and now contains two Reporting Responsibilities statements – one for the applicant to sign, which stays with the file, and one for the applicant to keep. This new form is designed to gather virtually all information that is needed to determine CAPI eligibility and payment amounts.

- SOC 453 (11/02 version) CAPI ELIGIBILITY STATEMENT OF HOUSEHOLD EXPENSES AND CONTRIBUTIONS

This form revises and replaces the previous SOC 453 and was designed to be more user-friendly. It is required whenever it is necessary to obtain household expense information for the purpose of determining the proper living arrangement category, or the amount (if any) of in-kind support and maintenance to be charged. Although not absolutely required in all cases, e.g. when the applicant lives alone and has rental liability, the county may require the form at its discretion whenever the county believes it is necessary in order to correctly determine eligibility and payment amount. This form should also be used after initial eligibility when a CAPI recipient reports a change in address or living arrangements.

- SOC 451 (08/02 version) CASH ASSISTANCE PROGRAM FOR IMMIGRANTS INTERIM ASSISTANCE REIMBURSEMENT AUTHORIZATION

This form revises and replaces the previous SOC 451. The immigration questions and the reporting responsibilities have been removed from this form because these items are now included on the SOC 814. The SOC 451 is now strictly an Interim Assistance Reimbursement Authorization. It is required

with all initial CAPI applications. Since the authorization is only valid for 12 months, it must also be completed and processed at any time subsequent to the initial 12 months of eligibility when a recipient is referred to apply for SSI/SSP.

## **AVAILABILITY OF NEW FORMS FOR ORDERING**

Counties should begin using all the new forms described in this ACL immediately. For camera-ready copies of these forms, please call Forms Management Unit (FMU) at (916) 657-1907 or CALNET at 437-1907. If your office has Internet access, you may obtain these forms from the California Department of Social Services' (CDSS) web page at: <http://www.dss.cahwnet.gov>. Counties can order supplies of the form through their usual ordering process. CDSS is in the process of translating these forms into the required languages.

Any questions regarding this letter should be directed to your Cash Assistance Programs Unit analyst at (916) 229-4582.

Sincerely,

***Original Document Signed By  
Donna L. Mandelstam on 1/8/03***

DONNA L. MANDELSTAM  
Deputy Director  
Disability and Adult Programs Division

Attachments

# STATEMENT OF FACTS CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)

**Instructions:** CAPI is a State-funded program for non-citizens only. Please print your answers clearly in blue or black ink. This application must be signed and dated by the applicant and spouse (if applicable).

If you need more space, use the "Remarks" section on page 6. Tell your worker if you need help in getting proof or filling out this form.

Type of Application:  Couple  Individual  Child  Child with Parents

## APPLICANT

<p>① a. First Name, Middle Initial, Last Name</p>	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER ____-____-____	LINKAGE <input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled	SSN	ID
b. Did you ever use any other names (including maiden name) or other Social Security Numbers? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						
c. Other names and Social Security Numbers used:						
d. RESIDENCE ADDRESS (NUMBER AND STREET)		CITY	ZIP CODE			
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		CITY	ZIP CODE			
(AREA CODE) HOME PHONE	(AREA CODE) WORK PHONE	(AREA CODE) MESSAGE PHONE	PERSON WITH WHOM TO LEAVE MESSAGE			
e. Do you intend to remain in California? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						

<p>② a. Do you have any physical or mental health problems or are you blind? (For example: high blood pressure, heart problems, diabetes, arthritis, osteoporosis, vision problems, depression, etc.) If yes, explain briefly:</p>	<b>YOU</b>	<b>YOUR SPOUSE</b>	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
b.	Date Problem(s) Began	Describe Health Problem(s)	
You			
Your Spouse			

## MARITAL STATUS

<p>③ a. Are you married? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO (Go to #4a.)</span></p>						
b. Spouse's Name (First, Middle Initial, Last)	DATE OF BIRTH	SOCIAL SECURITY NUMBER ____-____-____		LINKAGE <input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled	SSN	ID
c. Did your spouse ever use any other names (including maiden name) or other Social Security Numbers? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						
d. Other names and Social Security Numbers used by spouse:						
e. Are you and your spouse living together? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						
f. Date you began living apart:	SPOUSE'S ADDRESS:					
g. Is your spouse applying for CAPI? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						

COUNTY USE ONLY		
CASE NAME		
CASE NUMBER		
WORKER	DATE RCD	
Spouse  <input type="checkbox"/> DAPD Referral Completed <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored Deeming <input type="checkbox"/> SSI Referral Completed  Spouse eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No		

IMMIGRANT STATUS			COUNTY USE ONLY
<b>4</b> a. Are you a United States citizen? If yes, go to end of application and sign your name.	<b>YOU</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>YOUR SPOUSE</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. Have you or your spouse (or former spouse) ever been in the U.S. Military Service?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>5</b> a. Are you lawfully admitted for permanent residence in the United States?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
b. Give the date of lawful admission for permanent residence.	MO.   DAY   YR. ____/____/____	MO.   DAY   YR. ____/____/____	Resident card on file? <input type="checkbox"/> YES <input type="checkbox"/> NO
c. Did any person, institution or group sponsor your entry into the United States? If yes, go to #6. If no, go to #7.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	SPONSORED? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>6</b> a. Give the following information about your sponsor(s):			AFFIDAVIT OF SUPPORT  <input type="checkbox"/> Form I-134 <input type="checkbox"/> Form I-864
You <input type="checkbox"/> Spouse <input type="checkbox"/>	SPONSOR'S NAME _____	ADDRESS _____	TELEPHONE NO. (   )   _____
You <input type="checkbox"/> Spouse <input type="checkbox"/>	SPONSOR'S NAME _____	ADDRESS _____	TELEPHONE NO. (   )   _____
You <input type="checkbox"/> Spouse <input type="checkbox"/>	SPONSOR'S NAME _____	ADDRESS _____	TELEPHONE NO. (   )   _____
b. Is your sponsor deceased?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	VERIFIED  <input type="checkbox"/> Deceased <input type="checkbox"/> Disabled <input type="checkbox"/> Abused
c. Is your sponsor disabled?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
d. Are you being abused by your sponsor or his/her spouse?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>7</b> a. If not lawfully admitted for permanent residence, briefly explain your current immigration status with the Immigration and Naturalization Service (INS):			INS Documentation on file?  <input type="checkbox"/> Yes <input type="checkbox"/> No
YOU _____	YOUR SPOUSE _____		
b. Through what date will INS allow you to remain in the United States? (If indefinitely, indicate.)	<b>YOU</b>	<b>YOUR SPOUSE</b>	
<b>8</b> What is your Alien Registration Number?			
<b>9</b> What was your Port of Entry?			
RESIDENCY			
<b>10</b> Are you hiding or running from the law for a felony, attempted felony, or a parole or probation violation? If yes, go to the end of the application and sign your name.	<b>YOU</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>YOUR SPOUSE</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>11</b> a. When did you first make your home in the United States?	Date: _____	Date: _____	U.S. Resident?  <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you lived outside of the United States since then?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Give the dates you were outside of the United States. (month, day, year)	From: _____ To: _____	From: _____ To: _____	<input type="checkbox"/> Passport viewed and copy on file
<b>12</b> a. Within 30 days prior to applying for CAPI, were you outside of the United States?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Month aid begins: _____
b. Give the dates you left and returned to the United States.	Date left: _____ Date Returned: _____	Date left: _____ Date Returned: _____	
LIVING ARRANGEMENTS			
<b>13</b> Check the applicable block to show where you live now:			
<input type="checkbox"/> House <input type="checkbox"/> Room (commercial establishment) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Jail <input type="checkbox"/> Room (private home) <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Shelter for Battered Women <input type="checkbox"/> Hospital <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Other Institution <input type="checkbox"/> Other (specify) _____			
<b>14</b> a. Do you need assistance in your personal care or hygiene, (e.g., help with eating, dressing, bathing, taking medication, or moving about)?	<b>YOU</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>YOUR SPOUSE</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> IHSS Referral <input type="checkbox"/> NMOHC
b. Do you have adequate cooking and food storage facilities available?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cooking Facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No

**LIVING ARRANGEMENTS (CONTINUED)**

**COUNTY USE ONLY**

15 a. Do you and your spouse (if applicable) live alone?  YES  NO  YES  NO

b. If no, give the following information about everyone who lives with you (or with you and your spouse):

Name	Relationship to you or spouse	Sex		Date of Birth	Receives Public Assistance		Public Assistance Includes: • BIA • CalWORKs • CAPI • SSI/SSP • GA/GR • VA Pension
		M	F		Yes	No	

16 a. Do you rent, own or are you buying the place where you live?  YES  NO  YES  NO

b. If yes, how much is the monthly rent/mortgage payment? \$ \_\_\_\_\_

c. Does anyone who lives with you rent, own, or is he/she buying the place where you live?  YES  NO  YES  NO

Rental Liability/Ownership Verified

SOC 453?

Yes  No

**RESOURCES/PROPERTY**

17 a. Do you own or does your name appear on the title of any vehicle; (e.g., cars, trucks, boats, motorcycles, motor homes, etc.)?  YES  NO  YES  NO

Owner's Name	Description (Year, Make and Model)	Used For (Work, Medical Other)	Current Market Value	Amount Owed

Exempt Vehicle?

Yes  No

2nd Vehicle

Market Value: \$ \_\_\_\_\_

Encumbrances: - \$ \_\_\_\_\_

Equity Value: = \$ \_\_\_\_\_

18 a. Do you own or are you buying any life insurance policies?  YES  NO  YES  NO

Give the following information on each policy:	Policy #1	Policy #2
	Owner's Name	
Name of Insured		
Name of Insurance Company		
Policy Number		
Face Value	\$ _____	\$ _____
Cash Surrender Value	\$ _____	\$ _____
Date Purchased		
Loans Against the Policy	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

CSV?

Yes  No

Amount: \$ \_\_\_\_\_

19 Do you (either alone or jointly with another person) own any:  
a. Life estates, or ownership interest in an unprobated estate?  YES  NO  YES  NO

b. Household or personal items with a resale value of over \$500 ea.?  YES  NO  YES  NO

c. If yes, give the following information:

Owner's Name	Item	Resale Value	Amount owed on item
		\$ _____	\$ _____
		\$ _____	\$ _____

20 a. Do you own or does your name appear (either alone or jointly) on any of the following items either inside or outside of the United States?	YOU		YOUR SPOUSE		COUNTY USE ONLY
	YES	NO	YES	NO	
Cash (at home, with you, or anywhere else)					
Checking Accounts					
Savings Accounts					
Credit Union Accounts					
Certificates of Deposit					
Notes					
Bonds					
Money Market Accounts					
Stocks					
IRAs					
Other items that can be turned into cash					

b. Give the following information for any "yes" answers in 20a.

Verified?

Yes  No

Owner's Name	Name of Item	Value	Name of Bank or Financial Institution	Account Number

\$ \_\_\_\_\_  
 \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  
 \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

21 a. Do you own any land, buildings or does your name appear on the title of ANY property either inside or outside of the United States, other than at the address where you currently live?

YOU

YOUR SPOUSE

YES  NO  YES  NO

b. If yes, give the following information:

Verified?

Yes  No

Type of Property	Location of Property	Value
		\$ _____
		\$ _____

22 a. Have you sold, transferred title, disposed of or given away any money or property, including money or property in foreign countries, within 36 months of this application filing date, and after December 14, 1999?

YOU

YOUR SPOUSE

YES  NO  YES  NO

Sold for less than Market Value?

Yes  No

b. If yes, give the following information:

Date and Transfer Verified?

Yes  No

Description of Property	Current Market Value	Date of Transaction	Reason for Transaction

  

Name, Address, and Telephone Number of Buyer or Person Who Received Property	Relationship to Applicant	Sales Price or Other Agreement

Period of Ineligibility:

Beginning date: \_\_\_\_\_

Ending date: \_\_\_\_\_

23 a. Do you have any money set aside for burial expenses?

YOU

YOUR SPOUSE

YES  NO  YES  NO

Exempt?

Yes  No  
 Amount over \$1,500

Owner	Description (Type of Asset, Name of Organization)	Value	Date Set Aside	For Whose Burial (Relationship)

24 a. Do you own any cemetery plots, crypts, caskets, vaults, or urns?

YOU

YOUR SPOUSE

YES  NO  YES  NO

Revocable

Irrevocable

Owner	Description	Value	For Whose Burial (Relationship)

Revocable

Irrevocable

**INCOME**

**COUNTY USE ONLY**

**25** a. Have you received, or do you expect to receive income from any of the following sources?

Source	YOU		YOUR SPOUSE	
	YES	NO	YES	NO
Gifts/Support				
Social Security				
Veteran's Administration (VA)				
Supplemental Security Income (SSI)				
Unemployment Benefits				
State Disability				
Workers' Compensation				
Other Pensions/Annuities				
CalWORKs				
General Assistance/Relief				
Rental Income				
Insurance Payments				
Interest/Dividends				
Alimony/Child Support				
Other Income				

Verified?  
 Yes    No  
 \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  
 Total: \$ \_\_\_\_\_

b. For each "yes" answer, give the following information:

Person Receiving	Type	Gross Amount	How Often Received
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	

**26** a. Do you receive or do you expect to receive any wages?

YOU	YOUR SPOUSE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Verified?  
 Yes    No

b. If yes, give the following information:

Person Working	Employer's Name, Address, and Telephone Number	Gross Wages		Dates of Employment
		Amount	How Often Paid	
		\$ _____		From: _____ To: _____
		\$ _____		From: _____ To: _____

Paid:  
 Daily  
 Weekly  
 Bi-Weekly  
 Monthly  
 Twice Monthly  
 Fluctuating

**27** a. Have you been, or do you expect to be self-employed in the current year?

YOU	YOUR SPOUSE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Tax Return?  
 Yes    No

b. If yes, give the following information:

Type of Business	Last Year's		This Year's		Dates of Self-Employment
	Gross Income	Net Income (Loss)	Gross Income	Net Income (Loss)	

Year of Tax Return: \_\_\_\_\_

**28** If you are under age 65 and disabled, do you have any special expenses related to your illness or injury that are necessary for you to work? If yes, describe in "Remarks" on page 6.

YOU	YOUR SPOUSE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

IRWE?  
 Yes    No

**29** Are you currently receiving Food Stamps or have you recently applied for Food Stamps?

YOU	YOUR SPOUSE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO



## Important Information - Please Read Carefully

### REPORTING RESPONSIBILITIES

**You must tell us about any change within 10 days after the month it happens. Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty.**

### CHANGES TO REPORT

**WHERE YOU LIVE:**

- If you move.
- If you (or your spouse) leave your household for a calendar month or longer. For example, you enter a hospital or visit a relative.
- If you leave the United States for 30 days or more.
- If you are released from a hospital, nursing home, etc.
- If you are no longer a legal resident of the United States.

**HOW YOU LIVE:**

- If someone moves into or out of your household.
- If your marital status changes: You get married, separated, divorced, or your marriage is annulled or you start living together after a separation.
- If the amount of money you pay toward household expenses changes.
- The birth or death of any people with whom you live.

**INCOME:**

- If the amount of money (or checks or any other type of payment) you receive from someone or someplace goes up or down.
- If you start or stop work.
- If you start to receive money (or checks or any other type of payment).
- If your earnings go up or down.

**HELP YOU GET FROM OTHERS:**

- If the amount of help (money, food, clothing, or payment of household expenses) you receive goes up or down.
- If someone stops or starts helping you.

**THINGS OF VALUE THAT YOU OWN:**

- If the value of your total resources goes over \$2,000 (\$3,000 if you are married and live with your spouse).
- If you sell or give any things of value away.
- If you buy or are given anything of value.

**YOU ARE BLIND OR DISABLED:**

- If your condition improves or your doctor says you can return to work.
- If you stop or refuse any vocational rehabilitation services.
- If you go to work.

**UNMARRIED AND UNDER AGE 22:**

- If you are the parent of a child who receives CAPI benefits, you are to report if you or your child has a change in income, a change in marital status, a change in the value of anything the family owns, or if there is a change in residence.
- If the child starts or stops school.

**YOUR IMMIGRATION AND NATURALIZATION SERVICE (INS) STATUS CHANGES OR YOU BECOME A CITIZEN OF THE UNITED STATES.**

I/We understand my/our reporting responsibilities and agree to cooperate.

YOUR SIGNATURE

DATE

SPOUSE'S SIGNATURE

DATE

## KEEP FOR YOUR RECORDS

### Important Information - Please Read Carefully

#### REPORTING RESPONSIBILITIES

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#### CHANGES TO REPORT

##### WHERE YOU LIVE:

- If you move.
- If you leave the United States for 30 days or more.
- If you are no longer a legal resident of the United States.
- If you (or your spouse) leave your household for a calendar month or longer. For example, you enter a hospital or visit a relative.
- If you are released from a hospital, nursing home, etc.

##### HOW YOU LIVE:

- If someone moves into or out of your household.
- If the amount of money you pay toward household expenses changes.
- The birth or death of any people with whom you live.
- If your marital status changes: You get married, separated, divorced, or your marriage is annulled or you start living together after a separation.

##### INCOME:

- If the amount of money (or checks or any other type of payment) you receive from someone or someplace goes up or down.
- If you start to receive money (or checks or any other type of payment).
- If you start or stop work.
- If your earnings go up or down.

##### HELP YOU GET FROM OTHERS:

- If the amount of help (money, food, clothing, or payment of household expenses) you receive goes up or down.
- If someone stops or starts helping you.

##### THINGS OF VALUE THAT YOU OWN:

- If the value of your total resources goes over \$2,000 (\$3,000 if you are married and live with your spouse).
- If you sell or give any things of value away.
- If you buy or are given anything of value.

##### YOU ARE BLIND OR DISABLED:

- If your condition improves or your doctor says you can return to work.
- If you go to work.
- If you stop or refuse any vocational rehabilitation services.

##### UNMARRIED AND UNDER AGE 22:

- If you are the parent of a child who receives CAPI benefits, you are to report if you or your child has a change in income, a change in marital status, a change in the value of anything the family owns, or if there is a change in residence.
- If the child starts or stops school.

##### YOUR IMMIGRATION AND NATURALIZATION SERVICE (INS) STATUS CHANGES OR YOU BECOME A CITIZEN OF THE UNITED STATES.

# CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI) STATEMENT OF HOUSEHOLD EXPENSES AND CONTRIBUTIONS

APPLICANT'S/RECIPIENT'S NAME		APPLICANT'S SOCIAL SECURITY NUMBER	
SPOUSE'S NAME		SPOUSE'S SOCIAL SECURITY NUMBER	
RESIDENCE ADDRESS: STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER		MESSAGE TELEPHONE NUMBER	

## PART A - LIVING ARRANGEMENTS: Statement of the CAPI applicant/recipient and spouse

1. What date did you move to this address? \_\_\_\_\_  
(MONTH/DAY/YEAR)
2. How many people live in this residence? (Count yourself, your spouse, children and all others.) \_\_\_\_\_
3. Do all other household members receive some type of public assistance such as CalWORKs, BIA, SSI/SSP, VA Pension, CAPI, or GA/GR?  Yes  No
4. Do you (or your spouse) **own** or are you buying the home you live in?  Yes  No
5. Do you (or your spouse) **rent** the home you live in?  Yes  No
6. Are you (or anyone who lives with you) the parent or child of the landlord or landlord's spouse?  Yes  No
7. a. Does any organization or person **who does not live with you** help you (or your spouse) pay for food, rent, mortgage, property insurance, utility bills, or other household expenses? If yes, answer 7b.  Yes  No  
 b. Item: \_\_\_\_\_ Contributor: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_
8. Do you buy all your own food?  Yes  No

## PART B - TOTAL HOUSEHOLD EXPENSES: Expenses paid by entire household

9. a. Please enter the amount the entire household pays each month for the following items.  
 Write the total amount paid on behalf of everyone who lives in this residence, including yourself, spouse, children, and all others. Enter the full monthly rent or mortgage for the house or apartment, cost of food for everyone, etc.  
 Food (unless you buy your own food separately): \_\_\_\_\_ Gas: \_\_\_\_\_  
 Rent or mortgage: \_\_\_\_\_ Electric: \_\_\_\_\_  
 Property Insurance: \_\_\_\_\_ Water: \_\_\_\_\_  
 Property Taxes: \_\_\_\_\_ Sewage: \_\_\_\_\_  
 Garbage: \_\_\_\_\_
- b. If you share household expenses with others who live with you, write the amount you and your spouse contribute in cash each month. \$ \_\_\_\_\_
- c. What date did you start contributing this amount? \_\_\_\_\_  
(MONTH/DAY/YEAR)

## PART C - SIGNATURE: If the CAPI applicant/recipient pays household expenses to another person who lives in the same residence, or shares expenses with a person who lives in the same residence, that other person (called "Head of Household") must review this form, verify that it is accurate, and sign below.

### CAPI Applicant/Recipient

I declare under penalty of perjury under the laws of the State of California that all answers that I have given and all statements on this form are correct and true to the best of my knowledge.

SIGNATURE OF APPLICANT/RECIPIENT	DATE	SIGNATURE OF SPOUSE	DATE
----------------------------------	------	---------------------	------

### Head of Household

I declare under penalty of perjury under the laws of the State of California that all that all the information above regarding total household expenses and the CAPI applicant's/recipient's cash contributions is correct and true to the best of my knowledge.

SIGNATURE OF HEAD OF HOUSEHOLD	DATE	TELEPHONE NUMBER
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## CASH ASSISTANCE PROGRAM FOR IMMIGRANTS INTERIM ASSISTANCE REIMBURSEMENT AUTHORIZATION

NAME	SOCIAL SECURITY NUMBER
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I understand that the state-funded, Cash Assistance for Immigrants (CAPI), assistance authorized or paid to me, or on my behalf, by \_\_\_\_\_ County (DPSS) is considered interim assistance if it is paid during the period of time that my Supplemental Security Income/State Supplementary payment (SSI/SSP) eligibility is being determined. (Assistance financed wholly or partly with Federal Funds shall not be considered interim assistance.)

In consideration of such interim assistance paid to me, or on my behalf, I authorize the Commissioner of the Social Security Administration (SSA) to send the first payment of any SSI/SSP benefits, for which I may be determined eligible to the above agency.

I authorize the above agency to retain from that payment an amount equal to the sum of CAPI assistance payments the above agency and other California Interim Agencies paid to me, or on my behalf, to meet my basic needs both before and after the date of this authorization, but limited to the period of my SSI/SSP eligibility.

- Initial Claim      beginning with the month for which I am found eligible for an SSI/SSP payment and ending with the month my SSI/SSP payments begin;
- or
- Post Eligibility      beginning with the month for which my SSI/SSP payments are reinstated after a period of suspension or termination and ending with the month my payments resume.

I understand that, after making the above deduction from my SSI/SSP payments, the above agency shall pay to me the balance, if any, no later than ten (10) working days from the day the above agency receives my payment from SSA.

I understand that, if I feel that the amount deducted from my SSI/SSP retroactive payments is more than the amount of CAPI | assistance paid to me, or on my behalf by the agency, or I feel the above agency failed to pay me the excess within the ten (10) day period, I have a right to request a fair hearing from the State Department of Social Services. This request must be filed within ninety (90) days of the date the above agency notifies me of the receipt and disbursement of the payment.

I understand that if I file an initial claim for SSI/SSP benefits at a Social Security office within 60 days of the date the above agency receives this signed form, my eligibility for SSI/SSP benefits may begin as early as the date the above agency receives this signed form.

I understand that this authorization is effective from the date the above agency receives this signed form and that it will cease to have effect:

- Initial Claim      at the end of one(1) year from the date the above agency receives this signed form, unless I file for SSI/SSP within that time, or one of the events listed below occurs earlier, in which case the authorization will cease to have effect as of the date of such event:
- SSA makes an initial payment or reinstates payment on my claim;
  - SSA denies my claim and I do not file a timely appeal of that determination;
  - The above agency and I agree to terminate this agreement.
- or
- Post Eligibility      at the end of one (1) year from the date the above agency receives this signed form or at the end of the maximum period within which to request review of the determination to suspend or terminate my SSI/SSP payments, whichever period of time is longer, unless I file a timely request for review, or one of the events listed above occurs in which case the authorization will cease to have effect as of the date of such event.

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

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE		DATE SIGNED
SIGNATURE OF IA AGENCY REPRESENTATIVE	PHONE	DATE SIGNED