

DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814
(916) 322-5330



March 18, 1977

ALL-COUNTY LETTER NO. 77-17

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: UPDATING OF FORM CA 2 (FORMERLY WR 2)

REFERENCE:

Because of reduced stock supplies of the "Statement of Facts Supporting Eligibility for Assistance (Form CA 2)" we are reprinting the form and taking this opportunity to make a number of technical changes.

Attached is a facsimile of the revised CA 2. Also attached is a list of all changes being made to the form at this time. The changes reflect recent changes already made in regulations and make minor corrections and clarifications. This advance copy is being provided for the use of those counties that print their own forms. It will also provide lead time for eligibility worker training purposes.

The most significant changes made to the form are:

1. A statement has been added informing applicants of their right to voluntarily register for WIN; this replaces a similar statement on the IM-1. As a result, when using this revised CA 2, counties will no longer be required to use the IM-1 for documenting that exempt mothers have been informed of their right to volunteer for WIN. The individual work registration status can be documented under Section II, Item D of Form CA 3.
2. A UIB statement has been added to inform AFDC-U parents that they must apply for and accept any unemployment insurance benefits to which they are entitled. This addition conforms to Public Law 94-566 and EAS Manual Section 41-440.27 and .45, which became effective December 8, 1976.
3. The regulatory change requiring exclusion of household items and furnishings from the personal property evaluation [EAS 42-213.2 (i)] has been incorporated in the personal property section of the CA 2. All other references to household items and furnishings have been deleted from the form.

4. A space has been provided under the penalty of perjury statement on the Form CA 2 for the applicant/recipient to indicate the county where the form was signed. This is in accordance with Chapter 3, Article 2, Section 2015.5 of the California Code of Civil Procedures which requires a person to state the date and place of execution within this state or another state when a declaration is made under penalty of perjury.
5. A change that is not depicted on this advance copy is that the pages of the CA 2 will be attached at the top with a perforated stub rather than a staple. This change will substantially reduce printing time and cost.

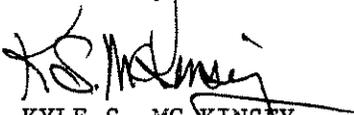
We anticipate having supplies of the updated Form CA 2 ready during the month of April. You will be notified of availability via Notice of Forms Change. You will still be able to use the current form until supplies are exhausted.

Any questions about the updated CA 2 should be directed to your AFDC Management Consultant at (916) 445-4458.

In addition to this updated CA 2, more substantial revisions to the form are being considered. Our plans are to reduce the size of the form by strictly limiting its contents to AFDC eligibility and grant information, make it simpler to understand and improve the format and structure. We are also considering the use of auxilliary forms to replace items which apply only to a small percentage of the total applicants. If you have suggestions for improving the form, including auxilliary forms, please provide them by April 15, to:

Miss Valta M. Adger
AFDC Program Systems Bureau
744 P Street, MS 16-31
Sacramento, CA 95814
(916) 322-5330

Sincerely,


KYLE S. MC KINSKY
Deputy Director

Attachments

cc: CWDA

FORM CA 2 (Formerly WR 2) Changes
March 1977

Cover Page (Front)

Instruction - Changed Form WR 2 to Form CA 2
- Changed the words "asked for" to "requested"

Statement of Responsibilities - Added Form (CA 7 or WR 7)
- Removed the words "T.V. and refrigerator"

Fair Hearing Requests - Changed 90 days to one year

Cover Page (Back)

- Added Voluntary Work Registration Statement
- Added Unemployment Insurance Benefits Statement
- Added heading for Social Security number requirement

Child Support Statement - Added CA 2.1 or WR 2.1
SSN Agreement - Added "...and provide such number(s) to the county welfare department when received."

Page 1, Item 1 - Reversed order of mailing address and home address

Item 4 - Removed Social Security number requirement for other persons living in the home.

P.L. Item - Added E (English) as 7th language specification.

Page 2, Item 6 - Changed WR 6 to CA 6

Item 10 - Changed "veteran" to "have been in the military service"
- Changed WR 5 to CA 5

Page 5, Item 14 - Changed 20 quarters to 17 quarters

Page 6, Item 17 - Deleted reference to household items and furnishings

Item 19 - Removed the words, "household and"

Page 7, Item 22 - Changed "children" to "persons"; added "and parents" and "who are eligible for AFDC."
- Added documentation space for CHDP Brochure given and the date

Certification - Changed WR 2 to CA 2

Signature Block - Removed duplicate mailing and home address
- Added "county where signed" box
- Added "for county use only" box

Food Stamp Certification

Pages 8 and 9 - Page 9 printed on the reverse side of page 8.

Page 9 - Changed Fair Hearing request from 90 days to one year.

**IMPORTANT INSTRUCTIONS TO APPLICANTS AND RECIPIENTS FOR COMPLETING
THE STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE (FORM CA 2)**

Complete each numbered/lettered box -- you cannot be granted aid until all questions have been answered.

If you need help filling out this form, you can have a friend or relative help you; if you have a problem with a question, circle the question number and go on to answer the next question. After you complete this form, ask your eligibility worker for help on those questions which you circled.

Use receipts and records to help you answer questions and be prepared to show them to support your answers. Use estimates only if you do not have and cannot get records or receipts. Please circle all estimates.

Questions beginning with the statement "I/We" refer to the natural, adoptive, married, or unmarried parent or needy caretaker relative, and all minor children for whom you are applying for aid.

If you need more space, attach a sheet of paper, note the question and item numbers and give the information requested.

STATEMENT OF RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS

IF YOU ARE GRANTED AID, YOU MUST FILL OUT A MONTHLY ELIGIBILITY REPORT (FORM CA 7 OR WR 7). IN ADDITION TO THIS MONTHLY REPORT, YOU MUST IMMEDIATELY REPORT THE FOLLOWING CHANGES TO YOUR ELIGIBILITY WORKER:

1. Report if you move or change your mailing address.
2. Report if anyone in your home:
 - gets married or becomes pregnant
 - returns to or drops out of school
 - starts or stops a job or a training program
 - moves in or out of your home
 - received money or property from any source such as: income tax refunds, retirement contribution refunds, insurance inheritances, gifts, awards, benefits, etc.
 - receives, transfers or sells any item of real or personal property, such as a house, car, insurance, etc.
 - is no longer incapacitated
 - attends college less than full time
 - has an increase or decrease in income
 - visits out of the state or county longer than 30 days

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 welfare 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 Benefit Payments. Your request must be received by the Department of Benefit Payments within one year 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 BENEFIT PAYMENTS, 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
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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
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VOLUNTARY WORK REGISTRATION

You have a right to voluntarily register for manpower services, training and employment even though you may be exempt from work registration under the WIN program requirements.

UNEMPLOYMENT BENEFITS

If you are an unemployed parent who is entitled to receive unemployment benefits, you MUST apply for and accept these benefits in order for your family to be eligible for aid.

SOCIAL SECURITY NUMBER REQUIREMENT

You must furnish or cooperate in securing a Social Security account number for each person (except for unborn children) for whom you are applying for AFDC.

— Furnishing Social Security Numbers (SSN's) is a condition of eligibility required by Section 402(a)(25) of the Social Security Act, and Department of Benefit Payments regulation EAS 40-105.2.

— The SSN will be used in the administration of the AFDC program.

STATEMENT OF FEDERAL CHILD SUPPORT PROGRAM REQUIREMENTS

The law provides that:

A. You must assign to the county paying aid any support rights you may have. This includes the right to child support and spousal support (alimony). This means that the receipt of an AFDC grant will automatically assign the accrued support rights of all persons for whom you are receiving aid.

B. If applicable to your case, you must cooperate with welfare and law enforcement officials in providing necessary information for the determination of paternity, location of the absent parent, and enforcement of the support obligation. You must fill out the form CA 2.1 or WR 2.1 (Child Support Questionnaire) or check the appropriate box indicating you will appear at the office of the District Attorney to show good cause why your cooperation should be excused.

IF YOU REFUSE TO ASSIGN SUPPORT RIGHTS OR COOPERATE:

- (1) You personally will be ineligible for an AFDC grant;
- (2) The AFDC grant for the children in your care will not be paid to you. The grant will go to a qualified representative who will pay the children's living expenses; and
- (3) Your case will be referred to the District Attorney for collection of support regardless of your refusal.

If I cannot presently furnish a Social Security number for all persons for whom I am applying for AFDC, I agree to cooperate in securing such number(s) by applying directly to the Social Security Administration, and provide such number(s) to the county welfare department when received.

I understand my responsibilities regarding the child support program and the assignment of support rights, and I agree to cooperate with the welfare department and the district attorney as specified above.

APPLICANT'S SIGNATURE	DATE
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I refuse to assign support rights.

APPLICANT'S SIGNATURE	DATE
-----------------------	------

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2. Report if anyone in your home:
 - gets married or becomes pregnant
 - returns to or drops out of school
 - starts or stops a job or a training program
 - moves in or out of your home
 - received money or property from any source such as: income tax refunds, retirement contribution refunds, insurance inheritances, gifts, awards, benefits, etc.
 - receives, transfers or sells any item of real or personal property, such as a house, car, insurance, etc.
 - is no longer incapacitated
 - attends college less than full time
 - has an increase or decrease in income
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Eligibility Worker's Signature	Eligibility Worker's Number	Date
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Applicant's Signature	Date
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APPLICANT'S SIGNATURE	DATE
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I refuse to assign support rights.

APPLICANT'S SIGNATURE	DATE
-----------------------	------

STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE

REQUIRED FORM - NO. SUBSTITUTE PERMITTED

Please print all required information in ink.

1 APPLICANT'S NAME (LAST, FIRST, MIDDLE INITIAL) _____ MAIDEN NAME _____ TELEPHONE NUMBER _____

HOME ADDRESS (IF YOU DO NOT HAVE A HOUSE NUMBER ON A CITY STREET, GIVE DIRECTIONS TO YOUR HOUSE AND ATTACH A MAP) _____

MAILING ADDRESS (ADDRESS TO WHICH THE AID PAYMENT IS TO BE MAILED - NUMBER, STREET, CITY, STATE, ZIP CODE) _____

2 LIST ALL PERSONS FOR WHOM YOU ARE REQUESTING AID.
Include any parent(s), unmarried children under 21 or unborn, and needy caretaker relatives.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	BIRTH DATE Mo/Day/Yr	BIRTH PLACE City/State	SEX M/F	COMPLETE FOR CHILDREN ONLY PARENT'S NAME (MO - Mother) (FA - Father) (Last, First, Middle Initial)	AID NEEDED DUE TO PARENT'S (✓)			
						DEATH	INCAPACITY	UNEMPLOYMENT	ABSENCE
MAN'S	- -	/ /							
WOMAN'S	- -	/ /							
UNMARRIED CHILDREN	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				
	- -	/ /			MO				
					FA				

3 LIST ALL UNMARRIED CHILDREN NOT LIVING IN YOUR HOME FOR WHOM YOU ARE REQUESTING AID.
(Explain below giving name, address and reason for living outside the home.)

4 LIST ALL OTHER PERSONS (friends, relatives, nonneedy caretaker) LIVING IN YOUR HOME.

NAME (Last, First, Middle Initial)	BIRTH DATE Mo/Day/Yr	BIRTH PLACE City/State	SEX M/F	RELATIONSHIP TO CHILDREN	DOES THIS PERSON HAVE INCOME?
	/ /				<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ /				<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ /				<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ /				<input type="checkbox"/> YES <input type="checkbox"/> NO

COUNTY USE ONLY

Return this form to _____

E.O. CODE						
Wh	Sp	BI	AA	AI	O	F
1	2	3	4	5	6	7
P.L. ITEM						
Sp	Ch	J	K	F	O	E
1	2	3	4	5	6	7

RESIDENCE MARITAL STATUS INCOME POTENTIAL

5 I/WE PRESENTLY LIVE IN CALIFORNIA AND INTEND TO CONTINUE LIVING HERE. Yes No
 If No, list the names of those persons who do not intend to continue living in California and explain.

NAME EXPLANATION

6 I/WE ARE CITIZENS OF THE U.S. Yes No
 If No, list names of all noncitizens for whom you are applying.

LAST NAME FIRST NAME MIDDLE INITIAL LAST NAME FIRST NAME MIDDLE INITIAL

7 PRESENT LEGAL MARITAL STATUS OF THE CHILD'S PARENT LIVING IN THE HOME: (Check one) Married Never Married Commonlaw Marriage Separated (legal) Separated (informal) Divorced Widowed
 If your spouse does not live with you, indicate reason (employment away from home, military, jail, etc.)

8 I/WE HAVE PRIVATE MEDICAL/HEALTH INSURANCE or have health insurance benefits through a present or past employer, union or employee group. If Yes, complete the following: Yes No

TYPE OF POLICY (Check ✓)	POLICY NUMBER	NAME OF INSURANCE COMPANY	PERSONS COVERED (Name)	MONTHLY PREMIUM PAID BY (Name)
<input type="checkbox"/> INDIVIDUAL POLICY <input type="checkbox"/> GROUP POLICY Name of Groups				\$
<input type="checkbox"/> INDIVIDUAL POLICY <input type="checkbox"/> GROUP POLICY Name of Groups				\$

9 I/WE HAD MEDICAL EXPENSES IN ANY OF THE 3 MONTHS PRIOR TO THE MONTH OF THIS APPLICATION. Was this medical service due to an accident for which medical costs will be paid by someone else? If you answered Yes to either of the above, complete the following. Yes No

NAME OF PATIENT	DATE OF TREATMENT	COST OF TREATMENT	COSTS PAID BY NAME (Individual/Insurance Company)
		\$	
		\$	

10 I/WE HAVE BEEN IN THE MILITARY SERVICE OR AM A SPOUSE, PARENT, OR CHILD OF A PERSON WHO HAS BEEN IN THE MILITARY SERVICE. Yes No

11 I/WE HAVE RECEIVED OR APPLIED FOR PUBLIC ASSISTANCE IN THE PAST. Yes No
 If Yes, complete the following: Public Assistance includes AFDC (Aid to Families with Dependent Children), Food Stamps, Medicare/Medical-Cal, SSI/SSP (Supplemental Security Income/State Supplemental Program), or General Relief. Include applications that have been denied.

PUBLIC ASSISTANCE	DATE APPLIED	DATE RECEIVED OR DATE EXPECTED	WHERE RECEIVED STATE/COUNTY

CA 5

CA 6 CA 6 CA 6

FOR COUNTY USE ONLY

12

A.

1/WE RECEIVE THE FOLLOWING GROSS (TOTAL) INCOME MONTHLY. Complete each item.

FOR COUNTY USE ONLY

SOURCE OF INCOME	If None Check (✓)	Have Applied For Check (✓)	1	2	3
			APPLICANT	SPOUSE	OTHER HOUSEHOLD MEMBER (Name)
			Monthly Amount	Monthly Amount	Monthly Amount
1. Earnings before deductions for members 14 and over (wages, salary, tips, commission, bonuses)			\$	\$	\$
2. Public Assistance or SSI/SSP			\$	\$	\$
3. Unemployment Insurance.			\$	\$	\$
4. Disability Insurance			\$	\$	\$
5. Worker's Compensation			\$	\$	\$
6. Veteran's Benefits			\$	\$	\$
7. Military Allotments			\$	\$	\$
8. GI Bill Benefits			\$	\$	\$
9. Social Security Payments/ Railroad Retirement			\$ CLAIM NUMBER	\$ CLAIM NUMBER	\$ CLAIM NUMBER
10. Retirement and/or Pensions			\$	\$	\$
11. Child Support and/or Alimony			\$	\$	\$
12. Contributions (parents, nonneedy relative caretakers, children, others)			\$	\$	\$
13. Rental (land, buildings, vehicles) (Attach a sheet of paper listing expenses)			\$	\$	\$
14. Payment from Boarder (including relative)			\$	\$	\$
15. Self-Employment/Farm Income (attach a sheet of paper listing expenses)			\$	\$	\$
16. Training Allowances			\$	\$	\$
17. Strike Benefits			\$	\$	\$
18. Student Scholarships, Grants, Loans.			\$	\$	\$
19. Prizes, Cash Gifts and Awards			\$	\$	\$
20. Income for Care of a Foster Child.			\$	\$	\$
21. Other (specify):			\$	\$	\$
22. Noncash Income					
Free Rent or Free Housing.			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Free Food			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Free Utilities			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Free Clothing			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Expenses \$ _____

Expenses \$ _____

B. 1/WE RECEIVE OR WILL RECEIVE INCOME LESS OFTEN THAN MONTHLY. Yes No

If Yes, complete the following (include interest, dividends, royalties, pending legal settlements, tax refunds, etc.):

NAME	SOURCE OF INCOME	RECEIVED HOW OFTEN (Quarterly, annually, etc.)	AMOUNT
			\$
			\$
			\$

INCOME

NAME AGE NAME OF SCHOOL OR TRAINING PROGRAM CITY NO. OF SCHOOL UNITS/HOURS

D. I/WE (16 and over) ARE PRESENTLY ATTENDING SCHOOL OR A TRAINING PROGRAM. If Yes, complete the following: Yes No

3. Daily Cost (round trip work and child care)	\$	\$	\$
2. Daily Miles (round trip work and child care)	Miles	Miles	Miles
1. Method			
Use your own car.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive car alone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car pool.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public (bus, train)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)			

C. TRANSPORTATION TO AND FROM WORK

6. Cost of Child Care	\$	\$	\$
5. Cost to worker for additional food, clothing and personal items required solely by work.	\$	\$	\$
4. Actual cost to worker of tools, materials, licenses, and union dues required by work.	\$	\$	\$
3. Required Retirement Contribution	\$	\$	\$
2. Required Payroll Deductions (Income tax, Social Security, Disability Ins.)	\$	\$	\$
1. Number of Dependents Claimed for tax withholding purposes			

B. MONTHLY DEDUCTIONS AND EXPENSES

7. Gross (total) Monthly Earnings (before deductions)	Cash	\$	Noncash	\$
		\$		\$

6. When Paid	Day of Week	How Often (every other week, twice a month, etc.)
5. Hours of Work	Per Week	Per Month
4. Days of Work Per Month	Days	Days
3. Address of Employer		
2. Name of Employer		
1. Working Member's Name	1	2

A. I/WE (16 or over) are presently working. If Yes, complete the following: Yes No

Country of Order	Address
Date of Order	Paid to Whom
Amount	State of Order

C. I/WE PAY THE FOLLOWING CHILD SUPPORT OR ALIMONY UNDER COURT ORDER MONTHLY:

FOR COUNTY USE ONLY

INCOME/DEDUCTIONS SCHOOL/TRAINING

E. I/We worked in the last 30 days but are not currently working.

Yes No

FOR COUNTY USE ONLY

I/We are on strike or a leave of absence from a job.

Yes No

I/We quit or refused or were fired from a job or job training in the last 30 days.

Yes No

If you answered Yes to any of the above, complete the following:

NAME	Name and Address of Employer/Training Program	Last Day of Job/Training (Mo/Day/Yr)	Amount of Last Pay	Hours of work training in last 30 days	REASON FOR LEAVING OR REFUSAL
			\$	Hours	
			\$	Hours	
			\$	Hours	

F. In order to be available for employment do you and/or other members of the family 16 or older need help with the care of a child or other persons in your household?

Yes No

14 COMPLETE THE FOLLOWING FOR THE CHILD'S FATHER WHO IS UNEMPLOYED AND LIVING IN THE HOME: If none, check (✓)

Received, or was eligible to receive unemployment insurance benefits within the last 12 months.

Yes No

Earned at least \$50 or attended 5 days or more of work training in any quarter within the last 17 quarters. If Yes, complete the following by entering the year and checking (✓) the appropriate quarters below.

Yes No

YEAR	1997		1998		1999		2000		2001		2002		2003		2004		2005	
QUARTER	JAN	APR	JUL	OCT	JAN	APR												
	MAR	JUN	SEP	DEC	MAR	JUN												
Work																		
Work Training																		

15 I/WE HAVE ONE OR MORE ASSETS.

Yes No

If Yes, complete the following and give the value of each asset. Assets include cash, savings, money in checking accounts, stocks or bonds, notes, mortgages, deeds of trust, sales contracts, estates, trust funds, life or burial insurance, etc.

ASSETS	APPLICANT	SPOUSE	OTHER HOUSEHOLD MEMBERS		
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

16 I/WE OWN OR USE ONE OR MORE MOTOR VEHICLES (car, truck, motorhike)

Yes No

If Yes, complete the following:

	1	2	3
Name of owner/user (if you don't own, check use only box)	<input type="checkbox"/> USE ONLY	<input type="checkbox"/> USE ONLY	<input type="checkbox"/> USE ONLY
Vehicle License Number and State of Registration			
Amount of last license fee paid	\$	\$	\$
Year, make and model			
Monthly payment	\$	\$	\$
Balance owed	\$	\$	\$
Finance Company	Name		
	Address		
Used for employment or training rehabilitation for employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYMENT

LIQUID ASSETS

VEHICLES

FOR COUNTY USE ONLY

18 I/WE HAVE SOLD OR DISPOSED OF PROPERTY IN THE PAST 2 YEARS.
 Check Yes if you have sold, transferred or given away any real estate or property (cash assets, trust funds, personal items, motor vehicles, boats, insurance policies, etc.).
 Yes No

TYPE (Land, home, apartment, etc.)	
USE (Home, income, investment)	
ADDRESS OR LOCATION	
OWNER(S)	
MORTGAGE COMPANY	
AMOUNT OWED	

18 I/WE OWN OR ARE BUYING REAL (ESTATE) PROPERTY.
 List all land and buildings that you own, have title to or share title on.
 Yes No

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PERSONAL PROPERTY ITEM	IF A GIFT (✓)	PURCHASE PRICE	PURCHASE DATE	AMOUNT OWED	NET MARKET VALUE
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
TOTAL					

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IF YES, COMPLETE THE FOLLOWING:

DO NOT LIST wedding or engagement rings, heirlooms, clothing, furniture, rugs, drapes, mirrors, appliances, air conditioners, kitchenware, televisions, music systems, cleaning and gardening equipment, or items that are rented or built-in as part of the house.

WORTH AT LEAST \$100 EACH (including gifts). Include such things as employment/rehabilitation items (inventory, tools, machines, etc.) and other personal property (livestock or fowl, jewelry, boats, campers, trailers, musical instruments, recreational equipment, power tools, etc.).

Yes No

PERSONAL/REAL PROPERTY

17

20 I/WE HAVE ONE OR MORE SPECIAL NEEDS.
If Yes, complete the following:

Yes No

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SPECIAL NEED	NAME	AMOUNT PER MONTH
Transportation to treatment not available in the community		\$
Special laundry service		\$
Housework (unavailable from other household persons)		\$
Special telephone equipment (hearing problem)		\$
Excessive use of one or more utilities		\$
(MEDICAL CONDITION AND DOCTOR'S NAME)		
Therapeutic diet		\$

21 I/WE NEED TO REPLACE ESSENTIAL HOUSEHOLD ITEMS, LOST OR DAMAGED DUE TO UNUSUAL CIRCUMSTANCES, WHICH CANNOT BE REPLACED FROM ANY SOURCE WITHOUT COST TO ME.

Yes No

If Yes, explain below (include date, place and circumstances resulting in loss). List items such as clothing bedding, dishes and kitchen utensils, cook stove, refrigerator, space heater, double bed, etc., and give the value of each.

22 SOCIAL SERVICES

A. I/We want information about a free medical examination for persons living in my home. Children and parents, up to the age of 21, who are eligible for AFDC, are entitled to free periodic medical exams, dental checks, eye and hearing tests, blood tests and immunizations. Follow-up medical treatment will be provided if necessary. Your doctor or the local health department may provide these services to your family.

Yes No

CHDP Brochure Given

Date _____

B. I/We want information about free family planning services. You are eligible for this service which can help you prevent unwanted pregnancy or to have children ONLY when you want them.

Yes No

C. I/We want to talk to a social worker about other available services or about arranging for transportation to obtain the above services.

Yes No

CERTIFICATION

I have received and read a copy of the instructions for completing Form CA 2 and I understand that I am required to notify my eligibility worker at once if there are any changes in my (and members of my household living with me) source and amount of income, real property holdings, personal possessions or expenses, the number of persons in my household (including unrelated adults) living with me, or any change of address, employment or training status.

I understand that if I am dissatisfied with the decision of the county concerning my application for aid, I have a right to appeal to the Department of Benefit Payments, 744 P Street, Sacramento, California 95814.

I understand that the foregoing statements of fact provided by me on this form are subject to investigation and verification and my signature constitutes authorization for these investigations.

After answering all questions, you, and your spouse or other parent of the child(ren) living in the home, must sign the form. If you make a mark, a witness must also sign below. An interpreter or someone completing this form for you also must sign.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS OF FACT PROVIDED BY ME ON THIS FORM ARE TRUE AND CORRECT.

SIGNATURE (OR MARK)	DATE SIGNED	COUNTY WHERE SIGNED
SIGNATURE OF SPOUSE OR OTHER PARENT LIVING IN HOME	DATE SIGNED	FOR COUNTY USE ONLY
SIGNATURE OF WITNESS, INTERPRETER, OR PERSON COMPLETING FORM FOR RECIPIENT	DATE SIGNED	

23 DO ANY OF THE PERSONS LIVING IN THE HOME PAY FOR BOARD, ROOM OR BOTH? Yes No FOR COUNTY USE ONLY
 If Yes, complete the following.

NAME (Last, First, Middle)	CHECK (✓)			AMOUNT PAID	HOW OFTEN		
	Room	Board	Both		Weekly	Monthly	Other

B. Does any member live in the home to provide nursing care, housekeeping services or care for children so that you or other members of the household can work? Yes No
 If Yes, give this person's name: _____

C. Do any other persons live in the home? If so, give names and status - for example, do they share the home or rent? Do they live as a separate household unit? Explain fully: _____

D. Do you have a place to prepare cooked meals where you live? Yes No

E. Are you or your spouse unable to prepare meals because of health problems? Yes No
 If Yes, do you receive meals from either:
 1. Meals on Wheels Program - Yes No 2. A communal dining facility - Yes No

F. Are you, or any member of the household, a member of a drug addict or alcoholic rehabilitation treatment center? (If Yes, give name) _____ Yes No
 Do you participate on a resident OR nonresident basis?

24 EXPENSES
 Give the following information about your household expenses.
 LIST ONLY THOSE EXPENSES ACTUALLY BEING PAID.
 Expenses paid by another person or source are to be included.

	AMOUNT	HOW OFTEN ARE EXPENSES ACTUALLY PAID					NUMBER OF MONTHS TO BE PAID
		Weekly	Every 2 Weeks	Twice Monthly	Monthly		
1. SHELTER							
a. Rent or mortgage payment on home	\$						
b. Utilities (if not included in rent)							
(1) Heating and cooking fuel (including wood)	\$						
(2) Electricity	\$						
(3) Telephone (basic charge for one)	\$						
(4) Water	\$						
(5) Sewage and/or garbage disposal fees	\$						
c. Taxes and assessments (yearly payments).	\$						
(1) Real estate taxes on home	\$						
(2) Special assessments (if required by law)	\$						
d. Home owner's fire insurance premium	\$						
2. MEDICAL							
a. Physician and dental services	\$						
b. Hospital or nursing care	\$						
c. Health insurance and medicare	\$						
d. Prescription drugs	\$						
e. Transportation costs for medical care	\$						
f. Other (specify) _____							
3. UNUSUAL							
a. Replacement or repair of property damaged or lost through vandalism, fire, theft, flood, storm, etc. (Explain on separate page, sign and date)	\$						
b. Funeral expenses paid by a member of the household (Explain on separate page, sign and date)	\$						
4. OTHER							
a. Payments for the care of a child or another person when necessary for a household member to work outside the home	\$						
b. Tuition and mandatory fees for education (do not include cost of books or materials)	\$						
(1) When paid? _____							
(2) For whom paid? _____							
(3) To whom paid? _____							
(4) Period covered by payments: From _____ To _____							
c. Court-ordered support/alimony payments	\$						

5. Does someone who is not a member of the household pay for any of these or other expenses? Yes No

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NAME OF PERSON (Last, First, Middle)	TYPE OF EXPENSE	AMOUNT PAID

25 DO YOU EXPECT ANY CHANGE IN YOUR HOUSEHOLD CIRCUMSTANCES - Income, resources, living arrangements, expenses or other circumstances - IN THE NEAR FUTURE? Yes No
If Yes, explain in detail.

26 IF ELIGIBLE FOR FOOD STAMPS I WOULD LIKE TO PURCHASE (check one): Twice a Month Once a Month

27 I/WOULD LIKE THE COST OF FOOD STAMPS WITHHELD FROM MY/OUR GRANT. Yes No

CERTIFICATION

I certify that this application has been examined by me (or read to me) and that the information given is true and correct to the best of my knowledge and belief. I agree to provide the County Food Stamp Office information necessary to verify any statements given in this application and hereby give permission to obtain such verification. I will also cooperate fully with state and federal personnel in a quality control review.

I agree to inform the County Food Stamp Office within 10 days of changes in income and/or deductions whenever such changes reach a total of more than \$25.00 per month within the period of eligibility or of any change in household composition or living arrangement, and of any change in any other information I have given since such changes may affect eligibility to purchase food coupons or the amount to be paid for them. I understand that when I plan to move to another county or state it may be possible for me to transfer my food stamp eligibility with me PROVIDED that I report the move to this food stamp office prior to my departure and obtain a transfer document FNS-286.

NONDISCRIMINATION: This application will be considered without regard to race, color, religious creed, national origin, or political beliefs.

I understand that I have a right to a hearing if I am not satisfied with the action taken on my application by the food stamp office. I may discuss the action with the County Welfare Department. If I am not satisfied with this discussion, I may request a hearing by the Department of Benefit Payments. The request may be written or oral, and must state why I am not satisfied. The request must be received by the Office of the Chief Referee, DBP, 744 P Street, Sacramento, California 95814, within one year of the postmarked date of the Notice of Adverse Action with which I am dissatisfied. I may be entitled to have my food stamps continued if I request a fair hearing within 10 days of the postmarked date of the Notice of Adverse Action.

BEFORE YOU SIGN YOUR NAME GO BACK AND CHECK TO SEE THAT EACH ITEM THAT APPLIES TO YOUR HOUSEHOLD HAS BEEN ANSWERED ACCURATELY.

PENALTIES FOR FRAUD: The state and federal law provides penalties including a fine, imprisonment or both for persons found guilty of obtaining food stamps for which they are not eligible by making false statements; or
FAILING TO REPORT PROMPTLY any changes in their circumstances. If evidence indicates that such individuals have willfully violated the law, they will be referred to the proper law enforcement authority for investigation and possible prosecution.
ANYONE WHO AIDS another person to obtain food stamps fraudulently is subject to the same penalties.

SIGNATURE OF HEAD OF HOUSEHOLD

DATE

SIGNATURE (AUTHORIZED REPRESENTATIVE OR OTHER PERSON COMPLETING APPLICATION)

DATE

If an Authorized Representative completes application attach written authorization of head of household or spouse.

IF SIGNED BY "X" SIGNATURE OF WITNESS

DATE

SIGNATURE OF ELIGIBILITY WORKER COMPLETING CERTIFICATION

DATE