STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814

May 30, 1984

ALL-COUNTY LETTER NO. 84-56

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: FORMS FOR WILLIAMS V. WOODS RETROACTIVE REGULATIONS

REFERENCE: MPP SECTION 50-012

This letter transmits English and Spanish Supplemental Claim Forms, computation worksheets, and the Statistical Report form to be used in conjunction with the Williams v. Woods retroactive regulations. The attached forms are camera-ready copies; counties should reproduce sufficient quantities of each form.

SUPPLEMENTAL CLAIM FORM (TEMP 1612)

This form is to be used, in accordance with MPP Section 50-012.323, when no case record exists for a claimant or when an existing case record does not contain sufficient information to process a claim. It must be sent to claimants with the specified Notice of Action which will be transmitted to you in a forthcoming letter. Before sending the form, the county welfare department's name and address must be entered in the box in the upper right hand corner of the first page, and the date by which the form must be returned must be entered in the space provided in the instructions to the claimant, also on the first page. That date, in accordance with MPP 50-012.323, shall be 30 calendar days from the date the Notice of Action and Supplemental Claim Form are sent to the claimant. Please note that claimants who received AFDC during their entire claim period are not required to complete all questions on this form. The Supplemental Claim Form is a required form; no substitutions or revisions are permitted.

COMPUTATION WORKSHEETS (TEMP 1612 A,B,C,D)

Four computation worksheets are provided for counties to use to compute the retroactive payment. These worksheets accommodate computation of retroactive benefits on both a monthly and an annual basis. Please note that the decision to do this computation on a monthly or annual basis is not a county option. In accordance with MPP Section 50-012.51, the nature of the computation (monthly or annualized) shall correspond to the nature of information provided by the claimant.

Computation Worksheet A (Temp 1612A) is to be used in accordance with MPP Section 50-012.52 to compute retroactive benefits for claimants who received AFDC during their claim period. Complete as many sections as necessary to cover the entire period claimed. In cases where the amount of Old Age, Survivors, and Disability Insurance (OASDI) benefits previously counted and/or the OASDI benefits available in cash fluctuated frequently, it may be necessary to use more than one worksheet to cover the period claimed.

Computation Worksheet B(Temp 1612B) and the two Income Computation Worksheets (Temp 1612 C and D) are to be used, in accordance with MPP Section 50-012.53, to compute retroactive benefits for claimants who were denied or discontinued from AFDC during their claim period. These worksheets are not designed to do the income eligibility determinations, but instead are to be used to compute retroactive benefits for those claimants who are determined to be income eligible. Worksheet B has been designed to accommodate the most common cases, those which had as income only in-kind benefits and OASDI benefits. For those cases that also had earned or other unearned income and/or that paid child/spousal support, the computation of that net non-exempt income should be done on the appropriate Income Computation Worksheet (Temp 1612C or Temp 1612D) depending on whether the period claimed is before or after December 1, 1981. Counties may use the Income Computation Worksheets as attachments to Worksheet B or may print them on the back of Worksheet B. Temp 1612C and D are also designed to accommodate the most common cases. Though total profit from earnings from self-employment is not specifically itemized on the worksheets, it must be included in the net non-exempt income computation when it is reported on the Supplemental Claim Form. Also, each column (Section) on Temp 1612D is designed to compute net nonexempt income for one person with earnings, or the entire assistance unit if only one member had earnings. If more than one person in the assistance unit had earned income, counties may use additional columns (Sections) to compute net nonexempt income for each person and then total the net nonexempt income (Item 11 on Temp 1612D) for the assistance unit before transferring it to Item E on Worksheet B. Complete as many worksheets as necessary to cover the entire period claimed. In cases where any of the amounts in Items B-E on Worksheet B fluctuate frequently, it may be necessary to use more than one worksheet to cover the period claimed.

If, for a portion of the period claimed the claimant received AFDC, and for the other portion of the period claimed the claimant was denied or discontinued from AFDC, both Computation Worksheet A and Computation Worksheet B should be used to compute retroactive benefits for the respective periods of the claim. Counties may use either the attached worksheets or modified versions of these worksheets. SDSS will not review modifications to the worksheets. However, any modifications may not alter the basic computations.

STATISTICAL REPORT

The Statistical Report form shall be used, in accordance with MPP Section 50-012.328, to report information required by the court order. The report is due to SDSS on December 12, 1984 and shall report on the disposition of Williams claims as of November 30, 1984. Counties which receive no Williams claims must submit a report which indicates that fact.

Those counties that report claims pending disposition on November 30 must submit a second report on January 7, 1985 to report the disposition on those pending claims. The second report should contain information only on those pending claims and shall show the number of pending claims in Item 1 on the report form. Those counties that have no pending claims on November 30 are not required to submit a second report. The Statistical Report form is a required form, and no substitutions or revisions are permitted.

If you have any questions regarding this letter, the Supplemental Claim Form, or the computation worksheets, please call Mara Jukich of the AFDC Program Development Bureau at (916) 322-5387. If you have any questions regarding the Statistical Report, please call the Statistical Services Branch at (916) 322-2230.

Robert Sertich

for KYLE S. McKINSEY
Deputy Director

Attachments

cc: CWDA

WILLIAMS v. WOODS

SUPPLEMENTAL CLAIM FOR BACK BENEFITS

INSTRUCTIONS: The welfare department does not have a case record for you. The information on this form is needed to help determine if you are eligible to back benefits and, if you are, the amount of back benefits you should receive.

This form is to be completed by the person(s) requesting back benefits. If you have any problems with any question, contact your local county welfare department for help. Use receipts and records to help answer these questions.

This form must be completed and returned to the address shown above no later than _____ or your claim will be denied.

* If you are claiming back benefits for when you **received AFDC**, complete questions 1, 2 and 8 and sign the bottom of the last page.
* If you are claiming back benefits for when you were **denied or discontinued from AFDC**, complete all of the questions (1 through 8) and sign the bottom of the last page.

PLEASE PRINT IN INK

PART I. *Everyone complete 1 and 2.*

(1) YOUR NAME (FIRST, MIDDLE INITIAL, LAST) | CURRENT TELEPHONE NUMBER ( )

CURRENT HOME ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

(2) A. List the month(s)/year(s) for which you are requesting back benefits from _____ County:
(If you were denied or discontinued from AFDC you may request back benefits from the date you applied or stopped receiving AFDC until you reached age 18.)

FROM: _____ / _____ through _____ / _____
MONTH YEAR MONTH YEAR

FROM: _____ / _____ through _____ / _____
MONTH YEAR MONTH YEAR

During any part of this time, did you receive AFDC? ☐ Yes ☐ No If yes, list the months you received AFDC:

FROM: _____ / _____ through _____ / _____
MONTH YEAR MONTH YEAR

FROM: _____ / _____ through _____ / _____
MONTH YEAR MONTH YEAR

B. During this period, my parent(s) received Social Security (green checks) for me in the following amount(s) (show full amount of checks and attach proof):

FROM: _____ / _____ through _____ / _____ $_____
MONTH YEAR MONTH YEAR AMOUNT

FROM: _____ / _____ through _____ / _____ $_____
MONTH YEAR MONTH YEAR AMOUNT

FROM: _____ / _____ through _____ / _____ $_____
MONTH YEAR MONTH YEAR AMOUNT

These benefits were paid because of my mother's or father's death or disability. His/her name is (was) _____ (FIRST, MIDDLE, LAST). His/Her Social Security Number is (was) _____.

C. During this period, did you receive any type of public assistance other than AFDC such as General Relief, Food Stamps, Medi-Cal? ☐ Yes ☐ No If Yes, complete the following:

NAME OF PERSON WHO RECEIVED ASSISTANCE	WHERE (SPECIFY COUNTY)	LAST DATE OF AID	TYPE OF AID

PART II. *Complete questions 3 - 7* **only** *if you are claiming back benefits for when you were denied or discontinued from AFDC.*

(3) During the months for which you are claiming back benefits (see "(2) A." above), were you a citizen of the United States? ☐ Yes ☐ No

If No, provide proof of alien status *(such as a green card or a document from the Immigration and Naturalization Service (INS) showing your status).*

4 A. For the time claimed in " 2 A." above, complete the following regarding your child(ren)(born and unborn) living in the home: (attach proof of each child's date of birth and Social Security Number)

During the whole time in " 2 A." above, were you or the other parent: (check " ✓ " below) (see explanation below)

NAME OF CHILD	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ABSENT FROM HOME	*UNEMPLOYED (SEE BELOW)	**INCAPACITATED (SEE BELOW)	DEAD
	/ /	— —				
	/ /	— —				
	/ /	— —				

* Unemployed — You or the second parent, if in your home, was not working at all or working less than 100 hours in the months for which you are claiming back benefits.

** Incapacitated — You or the second parent, if in your home, was physically or mentally ill or impaired to the extent that the ability to care for or support your child(ren) was reduced or eliminated in the months for which you are claiming back benefits.

B. During the period you are claiming back benefits for, was the other parent of the child(ren) listed in " 4 A." living in your home?

☐ YES ☐ NO If YES, and you want to claim back benefits for the other parent, complete 1 and 2 below:

1. NAME OF THE OTHER PARENT WHO LIVED WITH YOU DURING CLAIM PERIOD	HIS/HER SOCIAL SECURITY NUMBER (ATTACH PROOF OF NUMBER)

2. WAS HE/SHE A U.S. CITIZEN DURING CLAIM PERIOD?

☐ YES ☐ NO If NO, provide proof of alien status *(such as green card or document from INS).*

5 A. During the period for which you are claiming back benefits, did **you** have any income from earnings? ☐ YES ☐ NO

If YES, list all earnings and mandatory amount withheld from your pay check (Income Tax, Social Security, Disability Insurance, etc.) for the period for which back benefits are being claimed. Begin with the most recent job. If amount of income or employer changed, show the different amounts/employers on separate lines. Attach proof of the amounts (such as pay stubs, statements from employer(s), tax returns, W-2 forms). Attach additional sheets if necessary.

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	FULL TIME 1/	GROSS INCOME PER/MONTH *(before withholding)*	RECEIVED INCOME FROM: TO: *(month/year)*	MANDATORY $ AMOUNT WITHHELD FROM CHECK/MONTH
		☐ YES ☐ NO		FROM: / TO: /	
		☐ YES ☐ NO		FROM: / TO: /	
		☐ YES ☐ NO		FROM: / TO: /	
		☐ YES ☐ NO		FROM: / TO: /	

1/ Full time means 100 hours or more and 13 or more days per month (must be both).

B. If your child(ren)'s second parent was living in the home, did he/she have any income from earnings during the period for which you are claiming back benefits? ☐ YES ☐ NO

If YES, list all earnings and mandatory amount withheld from his/her pay check for the period for which back benefits are requested. Begin with the most recent job. If the amount of income or employer changed, show the different amounts/employers on separate lines. Attach proof of amounts (such as pay stubs, statements from employers, etc.) Attach additional sheets if necessary.

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	FULL TIME 1/	GROSS INCOME PER/MONTH *(before withholding)*	RECEIVED INCOME FROM: TO: *(month/year)*	MANDATORY $ AMOUNT WITHHELD FROM CHECK/MONTH
		☐ YES ☐ NO		FROM: / TO: /	
		☐ YES ☐ NO		FROM: / TO: /	
		☐ YES ☐ NO		FROM: / TO: /	
		☐ YES ☐ NO		FROM: / TO: /	

1/ Full time means 100 hours or more and 13 or more days per month (must be both).

C. Did you or your child(ren) or the other parent living in your home have income other than earnings during the period for which you are claiming back benefits (for example: Unemployment Insurance Benefits (UIB); SSI Benefits (Gold Check); Child/Spousal Support; Disability Insurance; Veteran's or GI Benefits; Retirement Pensions, Rental of Land, Buildings, Vehicles; Strike Benefits; Interest Dividends; Royalties; etc.)? ☐ YES ☐ NO

If YES, list all other income received by you, the other parent, and your child(ren) during the period for which back benefits are being claimed. Do **not** list Social Security listed in " 2 B." or income of your parent(s). If the amount of income changed, show the different amounts on separate lines. Attach proof of the amounts (award letter, statement from person/agency providing income). Attach additional sheets if necessary.

NAME OF PERSON WHO RECEIVED INCOME	SOURCE OF INCOME	WEEKLY/ MONTHLY AMOUNT	HOW OFTEN? *(WEEKLY/MONTHLY)*	RECEIVED INCOME FROM: TO: *(month/year)*
				FROM: / TO: /
				FROM: / TO: /
				FROM: / TO: /
				FROM: / TO: /

D. If you or the other parent had income (as shown above), list all child care, other work-related expenses (for example: transportation) and court ordered child support payments paid by you or the other parent living with you during the period for which back benefits are being claimed. Attach proof of payment. Attach additional sheets if necessary. If none, write "NONE".

TYPE OF EXPENSE	WHO PAID IT	TO WHOM IT WAS PAID	PAID FROM: TO: *(month/year)*	WEEKLY/ MONTHLY AMOUNT	HOW OFTEN? *(WEEKLY/MONTHLY)*
			FROM: / TO: /		
			FROM: / TO: /		
			FROM: / TO: /		
			FROM: / TO: /		
			FROM: / TO: /		

6 Did you or your child(ren) or the other parent own any property (for example: Cash, Savings and Checking Accounts; Securities; Stocks; Bonds; Mutual Fund Shares; Property (excluding home you lived in); Cash Surrender Value of Insurance Policies; Promissory Notes; Mortgages; Deeds of Trust; Automobiles; Boats; Campers; Jewelry; etc.) during the period for which you are claiming back benefits?

☐ YES ☐ NO If YES, complete the following and attach proof of value. (Attach additional sheets if necessary.)

TYPE OF PROPERTY *(FOR EXAMPLE: "1975 VW BUG")*	VALUE OF PROPERTY DURING TIME OWNED *(LESS AMOUNT YOU OWED)*	PROPERTY OWNED FROM: TO: *(month/year)*	NAME OF OWNER(S) OF PROPERTY
		FROM: / TO: /	
		FROM: / TO: /	
		FROM: / TO: /	
		FROM: / TO: /	
		FROM: / TO: /	
		FROM: / TO: /	

7 A. Was were your parent(s) living in the home during the period for which you are claiming back benefits? ☐ YES ☐ NO
If YES, complete the following:

PARENT'S NAME *(FIRST, MIDDLE INITIAL, LAST)*	DID PARENT HAVE INCOME DURING CLAIM PERIOD?
	☐ YES ☐ NO
	☐ YES ☐ NO

B. List any other persons living in the home during the period for which you are claiming back benefits:

NAME (FIRST, MIDDLE INITIAL, LAST)	AGE	RELATIONSHIP TO PARENT(S)

C. If your parent(s) had income during the period for which you are claiming back benefits, complete the following: *(Attach proof of source of income and amounts.)*

NAME OF PARENT WHO RECEIVED INCOME	SOURCE OF INCOME *(If earnings give employer's name)*	WEEKLY/MONTHLY GROSS AMOUNT *(Before Withholding)*	HOW OFTEN RECEIVED? *(WEEKLY/MONTHLY)*	RECEIVED INCOME FROM: TO: *(MONTH/YEAR)*	IF EARNINGS, WAS JOB FULL TIME? 1/	IF EARNINGS, $ AMOUNT WITHHELD FROM CHECK/MONTH
				FROM: / TO: /	☐ YES ☐ NO	
				FROM: / TO: /	☐ YES ☐ NO	
				FROM: / TO: /	☐ YES ☐ NO	
				FROM: / TO: /	☐ YES ☐ NO	

1/ Full time means 100 hours or more per month and 13 or more days per month (must be both).

D. Did your parent(s) make any child support or alimony payments during the period for which you are claiming back benefits?

☐ YES ☐ NO If YES, complete the following and attach proof of payment:

PERSON RECEIVING PAYMENT *(FIRST, MIDDLE INITIAL, LAST)*	RELATIONSHIP TO PARENT *(SON, EX—WIFE, ETC.)*	PAID FROM: TO: *(MONTH/YEAR)*	$ AMOUNT PAID
		FROM: / TO: /	
		FROM: / TO: /	
		FROM: / TO: /	

PART III. *Everyone complete 8 and sign.*

(8) A. If you received AFDC during the months for which you are claiming back benefits, attach, if available, any of the following as proof of your receipt of AFDC during each month: A copy of any document sent by the welfare department showing you were an AFDC recipient during these months or any other documents you may have stating you had an AFDC case during this time.

If you asked for and did not get AFDC, or were discontinued from AFDC, attach any document sent by the welfare department that shows you applied for and were denied AFDC or were discontinued from AFDC and when this was done.

These documents will help the welfare department determine the amount of back benefits you should get.

B. You must attach proof of information provided in questions (2), (3), (4), (5), (6), (7) and (8) A. above if it is reasonably available. If proof is not reasonably available, your statements alone will be sufficient. However, the county may check and verify your statements. If you have no proof, list the item and state the reason why the proof is not available, in the space below. (Attach additional sheets if necessary.)

I understand that the above statements of fact provided by me on this form are subject to investigation and verification.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT

SIGNATURE (OR MARK) OF APPLICANT/CARETAKER RELATIVE	DATE SIGNED	COUNTY WHERE SIGNED	
SIGNATURE OF OTHER PARENT WHO LIVED IN THE HOME DURING THE CLAIM PERIOD	DATE SIGNED	SIGNATURE OF WITNESS, INTERPRETER OR PERSON COMPLETING FORM FOR APPLICANT (IF APPROPRIATE)	DATE SIGNED

WILLIAMS vs. WOODS

RECLAMACIÓN SUPLEMENTAL DE BENEFICIOS ATRASADOS

INSTRUCCIONES: El departamento de bienestar no tiene ningún expediente a su nombre. Se necesita la información en esta forma para ayudar a determinar si usted califica para beneficios atrasados y, si califica, la cantidad de beneficios atrasados que debe recibir.

La(s) persona(s) que pida(n) los beneficios atrasados debe(n) llenar esta forma. Si tiene problemas con alguna pregunta, comuníquese con el departamento de bienestar del condado en su localidad para que le ayuden. Use recibos y documentación para ayudarse a contestar estas preguntas.

Debe llenar y devolver esta forma a la dirección que aparece en la parte superior no más tarde del _____, o se negará su reclamación.

* Si está reclamando beneficios atrasados para cuando **recibía Asistencia a Familias con Niños Necesitados (AFDC)**, conteste las preguntas 1, 2, y 8, y firme al final de la última página.
* Si está reclamando beneficios atrasados para cuando **se le negó o descontinuó AFDC**, conteste todas las preguntas (del 1 al 8), y firme al final de la última página.

POR FAVOR ESCRIBA CON TINTA Y LETRA DE IMPRENTA

PARTE 1. *Las preguntas 1 y 2 deben ser contestadas por todos*

(1) SU NOMBRE (NOMBRE, INICIAL, APELLIDO)		NO. DE TELÉFONO ACTUAL ( )	
DOMICILIO ACTUAL DE SU HOGAR	CIUDAD	ESTADO	ZONA POSTAL
DIRECCIÓN PARA EL CORREO (SI ES DIFERENTE A LA DE ARRIBA)	CIUDAD	ESTADO	ZONA POSTAL

(2) A. Escriba los meses y años para los cuales está pidiendo beneficios atrasados de parte del Condado de : _____
(Si se le negó o descontinuó AFDC, puede pedir beneficios atrasados a partir de la fecha en la cual solicitó o paró de recibir AFDC hasta la fecha en que cumplió 18 años de edad.)

DESDE: _____ / _____ hasta _____ / _____
MES AÑO MES AÑO

DESDE: _____ / _____ hasta _____ / _____
MES AÑO MES AÑO

Durante cualquier parte de este período de tiempo, ¿recibió usted AFDC? ☐ SÍ ☐ NO
Si es así, escriba los meses en los cuales recibió AFDC:

DESDE: _____ / _____ hasta _____ / _____
MES AÑO MES AÑO

DESDE: _____ / _____ hasta _____ / _____
MES AÑO MES AÑO

B. Durante este período, mi(s) padre(s) recibió (recibieron) Seguro Social (cheques verdes) por mí, por las siguientes cantidades (escriba el monto total de los cheques y adjunte comprobantes):

DESDE: _____ / _____ hasta _____ / _____ $_____
MES AÑO MES AÑO CANTIDAD

DESDE: _____ / _____ hasta _____ / _____ $_____
MES AÑO MES AÑO CANTIDAD

DESDE: _____ / _____ hasta _____ / _____ $_____
MES AÑO MES AÑO CANTIDAD

Estos beneficios fueron pagados debido a la muerte o incapacidad de mi madre o padre, cuyo nombre es (era) _____ (NOMBRE, INICIAL, APELLIDO). Su número de Seguro Social es (era) _____.

C. Durante este período, ¿recibió usted cualquier clase de asistencia pública además de AFDC, tales como Ayuda General (General Relief), Estampillas para Comida, Medi-Cal? ☐ SÍ ☐ NO
Si es así, complete lo siguiente:

NOMBRE DE LA PERSONA QUE RECIBIÓ ASISTENCIA	DONDE (ESPECIFIQUE CUÁL CONDADO)	ÚLTIMA FECHA EN QUE RECIBIÓ ASISTENCIA	CLASE DE ASISTENCIA

PARTE II. *Complete las preguntas del 3 al 7* **solamente** *si está reclamado beneficios atrasados para cuando se le negó o descontinuó AFDC.*

(3) Durante los meses para los cuales está reclamando beneficios atrasados (según la Sección (2) A, que aparece arriba), ¿era usted ciudadano de los Estados Unidos? ☐ SÍ ☐ NO
Si No, proporcione comprobante de su estado legal como extranjero (como por ejemplo su visa de inmigración, o un documento del Servicio de Inmigración y Naturalización (INS) que muestre su estado legal).

4 A. Respecto a la fecha reclamada en la sección 2 A, complete lo siguiente en cuanto a sus hijos (nacidos y aún no nacidos) que vivían en el hogar: (adjunte comprobantes de la fecha de nacimiento y número de seguro social de cada niño)

Durante todo el tiempo anotado en la sección 2 A, ¿estaba usted o el otro padre: (marque " ✓ " abajo, viendo la explicación de los términos)

NOMBRE DEL(A) HIJO(A)	FECHA DE NACIMIENTO	NO. DE SEGURO SOCIAL	AUSENTE DEL HOGAR	*DESEMPLEADO (LEA ABAJO)	**INCAPACITADO (LEA ABAJO)	MUERTO
	/ /	— —				
	/ /	— —				
	/ /	— —				

* Desempleado — Usted o el otro padre, si estaba en su hogar, no estaba trabajando o trabajaba menos de 100 horas en los meses para los cuales está reclamando beneficios atrasados.

** Incapacitado — Usted o el otro padre, si estaba en su hogar, estaba física o mentalmente enfermo o impedido a tal grado que la habilidad para cuidar o sostener a sus niños fue reducida o eliminada en los meses para los cuales usted está reclamando los beneficios atrasados.

B. Durante el período para el cual usted está reclamando beneficios atrasados, ¿estaba el otro padre de los niños nombrados en la sección 4 A viviendo en su hogar? ☐ SÍ ☐ NO

Si contestó que SÍ, y, quiere reclamar beneficios atrasados para el otro padre, complete las preguntas 1 y 2 a continuación:

1. NOMBRE DEL OTRO PADRE QUE VIVÍA CON USTED DURANTE EL PERÍODO DE RECLAMO | SU NÚMERO DE SEGURO SOCIAL (ADJUNTE COMPROBANTE DEL NÚMERO)

2. ¿ERA ÉL (ELLA) CIUDADANO DE LOS ESTADOS UNIDOS DURANTE EL PERÍODO DE RECLAMO?
Si NO, proporcione comprobante de su estado legal de extranjero (tal como la visa de inmigración o documentación de INS). ☐ SÍ ☐ NO

5 A. Durante el período para el cual usted está reclamando beneficios atrasados, ¿tenía **usted** algún ingreso que provenía de salarios? ☐ SÍ ☐ NO

Si contestó que SÍ, escriba todos los salarios y la cantidad mandatoria retenida de su cheque de pago (impuestos sobre ingresos, seguro social, seguro contra incapacidad, etc.) para el período para el cual se están reclamando beneficios atrasados. Comience con el empleo más reciente. Si la cantidad de los ingresos o el empleador ha cambiado, escriba las diferentes cantidades o empleadores en líneas distintas. Adjunte comprobantes de las cantidades (tales como talones de pago, declaraciones de los empleadores, reembolsos de impuestos, formas W-2). Adjunte hojas adicionales, si es necesario.

NOMBRE DEL EMPLEADOR	DOMICILIO DEL EMPLEADOR	TIEMPO COMPLETO 1/	INGRESOS BRUTOS MENSUALES (antes de las deducciones)	INGRESOS RECIBIDOS DESDE: HASTA: (mes/año)	$ CANTIDAD MANDATORIA RETENIDA DEL CHEQUE MENSUALMENTE
		☐ SÍ ☐ NO		DESDE: / HASTA: /	
		☐ SÍ ☐ NO		DESDE: / HASTA: /	
		☐ SÍ ☐ NO		DESDE: / HASTA: /	
		☐ SÍ ☐ NO		DESDE: / HASTA: /	

1/ Tiempo completo significa 100 horas o más y 13 o más días al mes (tienen que ser ambas cosas).

B. Si el otro padre de sus niños estaba viviendo en el hogar, tenía él/ella ingresos provenientes de salarios durante el período para el cual usted está reclamando beneficios atrasados? ☐ SÍ ☐ NO

Si contestó que SÍ, escriba todos los salarios y cantidad mandatoria retenida del cheque de él/ella para el período para el cual se están pidiendo beneficios astrasados. Comience con el empleo más reciente. Si la cantidad de los ingresos o el empleador cambió, muestre las diferentes cantidades/empleadores en líneas distintas. Adjunte comprobante de las cantidades (tales como talones de pago, declaraciones de los empleadores, etc.) Adjunte hojas adicionales, si es necesario.

NOMBRE DEL EMPLEADOR	DOMICILIO DEL EMPLEADOR	TIEMPO COMPLETO 1/	INGRESOS BRUTOS MENSUALES (antes de las deducciones)	INGRESOS RECIBIDOS DESDE: HASTA: (mes/año)	$ CANTIDAD MANDATORIA RETENIDA DEL CHEQUE MENSUALMENTE
		☐ SÍ ☐ NO		DESDE: / HASTA: /	
		☐ SÍ ☐ NO		DESDE: / HASTA: /	
		☐ SÍ ☐ NO		DESDE: / HASTA: /	
		☐ SÍ ☐ NO		DESDE: / HASTA: /	

1/ Tiempo completo significa 100 horas o más y 13 o más días al mes (tienen que ser ambas cosas).

C. ¿Tuvo usted o sus hijos o el otro padre que vivía en su hogar ingresos además de los salarios durante el período para el cual usted está reclamando beneficios atrasados (por ejemplo: Beneficios del Seguro Contra Desempleo (UIB), beneficios de SSI (cheque dorado), Sostenimiento a Hijos/Pensión Alimenticia, Seguro Contra Incapacidad, Beneficios a Veteranos o Militares (GI), pensiones de jubilación, renta de terreno, edificios, vehículos, beneficios a huelguistas, dividendos por interés, regalías, etc.)?

☐ SÍ ☐ NO

Si contestó que SÍ, escriba todos los ingresos recibidos por usted, el otro padre, y sus hijos durante el período para el cual se están reclamando beneficios atrasados. **No** escriba los provenientes del seguro social que ya anotó en la sección 2 B. o los ingresos de los padres de usted. Si la cantidad de los ingresos cambió, muestre las diferentes cantidades en líneas distintas. Adjunte comprobantes de las cantidades (carta de notificación de beneficios, declaración de la persona/agencia que proporciona los ingresos). Adjunte hojas adicionales si es necesario.

NOMBRE DE LA PERSONA QUE RECIBIÓ LOS INGRESOS	FUENTE DE LOS INGRESOS	CANTIDAD SEMANAL/ MENSUAL	¿CADA CUÁNTO TIEMPO? *(SEMANAL/ MENSUALMENTE)*	INGRESOS RECIBIBIDOS DESDE: HASTA: *(mes/año)*
				DESDE: / HASTA: /
				DESDE: / HASTA: /
				DESDE: / HASTA: /
				DESDE: / HASTA: /

D. Si usted o el otro padre tenía ingresos (según se muestra arriba), escriba todos los gastos por cuidado de niños, otros gastos relacionados con el trabajo (por ejemplo transportación) y pagos de sostenimiento a hijos, ordenados por la corte, pagados por usted o por el otro padre que vivía con usted durante el período para el cual se están reclamando beneficios atrasados. Adjunte comprobante de pago. Adjunte hojas adicionales si es necesario. Si no tuvo ningunos gastos, escriba "NINGUNOS".

CLASE DE GASTO	QUIÉN LO PAGÓ	A QUIÉN SE LE PAGÓ	PAGADO DESDE: HASTA: *(mes/año)*	CANTIDAD MENSUAL/ SEMANAL	¿CON CUÁNTA FRECUENCIA? *(SEMANAL/MENSUAL)*
			DESDE: / HASTA: /		
			DESDE: / HASTA: /		
			DESDE: / HASTA: /		
			DESDE: / HASTA: /		

6 ¿Era usted o sus hijos o el otro padre dueño de cualquier propiedad (por ejemplo dinero en efectivo, cuentas de ahorros y de cheques, valores, acciones, bonos, acciones de fondo mutualista (mutual fund shares), propiedad (excluyendo el hogar en que usted vivía), valor efectivo de rescate (cash surrender value) de pólizas de seguro, pagarés, hipotecas, escrituras de fideicomiso (deeds of trust), automóviles, lanchas, vehículos de acampar, joyería, etc.) durante el período para el cual usted está reclamando beneficios atrasados?

☐ SÍ ☐ NO

Si contestó que SÍ, complete lo siguiente y adjunte comprobante del valor. (Adjunte hojas adicionales si es necesario.)

CLASE DE PROPIEDAD *(POR EJEMPLO: "VOLKSWAGEN 1975")*	VALOR DE LA PROPIEDAD DURANTE EL TIEMPO EN QUE ERA DUEÑO DE ELLA *(MENOS LA CANTIDAD QUE DEBÍA)*	PROPIEDADES DE LAS QUE ERA DUEÑO DESDE: HASTA: *(mes/año)*	NOMBRE DEL(OS) DUEÑO(S) DE LAS PROPIEDADES
		DESDE: / HASTA: /	
		DESDE: / HASTA /	
		DESDE: / HASTA: /	
		DESDE: / HASTA: /	
		DESDE: / HASTA: /	
		DESDE: / HASTA: /	

7 A. ¿Vivía(n) su(s) padre(s) en el hogar durante el período para el cual usted está reclamando beneficios atrasados? ☐ SÍ ☐ NO

Si contestó que SÍ, complete lo siguiente:

NOMBRE DEL PADRE/MADRE *(NOMBRE, INICIAL, APELLIDO)*	¿TENÍA DICHO PADRE INGRESOS DURANTE EL PERÍODO DE RECLAMO?
	☐ SÍ ☐ NO
	☐ SÍ ☐ NO

B. Escriba los nombres de las otras personas que vivían en el hogar durante el período para el cual usted está reclamando beneficios atrasados:

NOMBRE *(NOMBRE, INICIAL, APELLIDO)*	EDAD	RELACIÓN CON LOS PADRES

C. Si su(s) padre(s) tenía(n) ingresos durante el período para el cual usted está reclamando beneficios atrasados, complete lo siguiente:
(Adjunte comprobantes de las fuentes de ingresos y las cantidades.)

NOMBRE DEL PADRE/MADRE QUE RECIBÍA LOS INGRESOS	FUENTE DE LOS INGRESOS *(Si eran salarios, dé el nombre del empleador)*	CANTIDAD BRUTA SEMANAL/MENSUAL *(Antes de las deducciones)*	¿RECIBIDOS CADA CUÁNTO TIEMPO? (SEMANAL/MENSUALMENTE)	INGRESOS RECIBIDOS DESDE: HASTA: *(MES/AÑO)*	SI ERAN 1/ SALARIOS, ¿TRABAJABA TIEMPO COMPLETO	SI ERAN SALARIOS, $ CANTIDAD RETENIDA DEL CHEQUE MENSUALMENTE
				DESDE: / HASTA: /	☐ SÍ ☐ NO	
				DESDE: / HASTA: /	☐ SÍ ☐ NO	
				DESDE: / HASTA: /	☐ SÍ ☐ NO	
				DESDE: / HASTA: /	☐ SÍ ☐ NO	

1/ Tiempo completo significa 100 horas o más al mes y 13 o más días al mes (tienen que ser ambas cosas).

D. ¿Hacía su padre/madre pagos de sostenimiento a hijos o de pensión alimenticia durante el período para el cual usted está reclamando beneficios atrasados? ☐ SÍ ☐ NO

Si contestó que SÍ, complete lo siguiente y adjunte comprobantes de los pagos:

PERSONA QUE RECIBIÁ LOS PAGOS *(NOMBRE, INICIAL, APELLIDO)*	RELACIÓN CON EL PADRE/MADRE *(HIJO, EX—ESPOSO, ETC.)*	PAGADO DESDE: HASTA: *(MES/AÑO)*	$ CANTIDAD PAGADA
		DESDE: / HASTA: /	
		DESDE: / HASTA: /	
		DESDE: / HASTA: /	

PARTE III. *Todos deben llenar la Sección 8, y firmar abajo.*

(8) A. Si usted recibía AFDC durante los meses para los cuales está reclamando beneficios atrasados, adjunte, si los puede conseguir, cualquiera de los documentos indicados enseguida como comprobantes de que recibía AFDC durante cada mes: Una copia de cualquier documento enviado por el departamento de bienestar que muestre que usted recibía AFDC durante estos meses o cualesquier otros documentos que usted pueda tener que comprueben que había un caso de AFDC a su nombre durante este período.

Si usted solicitó y no recibío AFDC, o se le descontinuó la AFDC, adjunte cualquier documento enviado por el departamento de bienestar que muestre que usted solicitó y se le negó la AFDC, o que se le descontinuó la AFDC, y la fecha en que esto ocurrió.

Estos documentos ayudarán al departamento de bienestar del condado a determinar la cantidad de beneficios atrasados que usted debe recibir.

B. Usted debe adjuntar comprobantes de la información proporcionada en las preguntas (2), (3), (4), (5), (6), (7), y (8)A si las puede conseguir de una manera razonable. Si no las puede conseguir razonablemente, sus declaraciones solas serán suficientes. Sin embargo, el condado puede averiguar sobre y verificar sus declaraciones. Si usted no tiene comprobantes, indique para cuál pregunta y dé la razón por la cual no tiene comprobantes a su disposición en el espacio proporcionado a continuación. (Adjunte hojas adicionales si es necesario.)

Comprendo que las declaraciones de hechos proporcionadas por mí en esta forma están sujetas a investigación y verificación.

DECLARO BAJO PENA DE PERJURIO QUE LAS DECLARACIONES EN ÉSTA SON VERDADERAS Y CORRECTAS.

FIRMA (O MARCA) DEL(A) SOLICITANTE/PERSONA ENCARGADA DEL CUIDADO CONTINUO DE UN PARIENTE	FECHA EN QUE SE FIRMÓ	CONDADO DONDE SE FIRMÓ	
FIRMA DEL OTRO PADRE/MADRE QUE VIVÍA EN EL HOGAR DURANTE EL PERÍODO DE RECLAMACIÓN	FECHA EN QUE SE FIRMÓ	FIRMA DEL(A) TESTIGO, INTÉRPRETE O PERSONA QUE LLENÓ ESTA FORMA POR EL/LA SOLICITANTE (SI APLICA)	FECHA EN QUE SE FIRMÓ

WILLIAMS V. WOODS

COMPUTATION WORKSHEET — A (CLAIMANT RECEIVED AFDC)

CLAIMANT NAME | CASE NUMBER

INSTRUCTIONS: *Complete only for those claimants who received AFDC during the period claimed. Compute retroactive benefits on a monthly or annual basis depending on the nature of information provided by the claimant. Use monthly amounts when computing benefits on a monthly basis. Use annualized amounts when computing benefits on an annual basis. Complete A - F and G for all cases. When amounts in B or C change, continue the computation in the next Section. Complete as many Sections (or pages) as necessary to cover the entire period claimed.*

SECTION _____ *(Fill in section number)*

(CHECK ONE)

☐ Monthly Amounts
☐ Annual Amounts

A. FROM: _____ / _____ (MONTH / YEAR) Through _____ / _____ (MONTH / YEAR) = _____ (NUMBER) Months

B. Original Amount of OASDI Benefits Counted (from Case Record or Supplemental Claim Form, Item 2B) ..... $_____

C. Amount of OASDI Benefits Available in Cash (from Notice/Claim Form) ..... _____

D. Difference (B Minus C) ..... $_____

E. 1. If Monthly Amounts, _____ (NUMBER) Months in "A" x $_____ ("D") = $_____ (TOTAL) (Enter this amount in "F".)

2. If Annual Amounts, Enter Amount from "D" in "F".

F. TOTAL PAYMENT FOR TIME PERIOD ..... $_____

SECTION _____ *(Fill in section number)*

(CHECK ONE)

☐ Monthly Amounts
☐ Annual Amounts

A. FROM: _____ / _____ (MONTH / YEAR) Through _____ / _____ (MONTH / YEAR) = _____ (NUMBER) Months

B. Original Amount of OASDI Benefits Counted (from Case Record or Supplemental Claim Form, Item 2B) ..... $_____

C. Amount of OASDI Benefits Available in Cash (from Notice/Claim Form) ..... _____

D. Difference (B Minus C) ..... $_____

E. 1. If Monthly Amounts, _____ (NUMBER) Months in "A" x $_____ ("D") = $_____ (TOTAL) (Enter this amount in "F".)

2. If Annual Amounts, Enter Amount from "D" in "F".

F. TOTAL PAYMENT FOR TIME PERIOD ..... $_____

SECTION _____ *(Fill in section number)*

(CHECK ONE)

☐ Monthly Amounts
☐ Annual Amounts

A. FROM: _____ / _____ (MONTH / YEAR) Through _____ / _____ (MONTH / YEAR) = _____ (NUMBER) Months

B. Original Amount of OASDI Benefits Counted (from Case Record or Supplemental Claim Form, Item 2B) ..... $_____

C. Amount of OASDI Benefits Available in Cash (from Notice/Claim Form) ..... _____

D. Difference (B Minus C) ..... $_____

E. 1. If Monthly Amounts, _____ (NUMBER) Months in "A" x $_____ ("D") = $_____ (TOTAL) (Enter this amount in "F".)

2. If Annual Amounts, Enter Amount from "D" in "F".

F. TOTAL PAYMENT FOR TIME PERIOD ..... $_____

G. TOTAL RETROACTIVE PAYMENT (Enter amounts from "F" above.)

Section # _____ $_____
Section # _____ $_____
Section # _____ $_____
TOTAL $_____

E.W. SIGNATURE AND DATE	SUPERVISOR SIGNATURE AND DATE

WILLIAMS V. WOODS

COMPUTATION WORKSHEET — B (CLAIMANT DENIED/DISCONTINUED FROM AFDC)

CLAIMANT NAME	CASE NUMBER

INSTRUCTIONS: *Complete only for those claimants who were denied or discontinued and who were income eligible during the period claimed. Compute retroactive benefits on a monthly or annual basis depending on the nature of information provided by the claimant. Use monthly amounts on this worksheet and corresponding Sections of the Income Computation Worksheet(s) when computing benefits on a monthly basis. Use annualized amounts on this worksheet and corresponding Sections of the Income Computation Worksheet(s) when computing benefits on an annual basis. Complete A - I and J for all cases. Compute net nonexempt income including deduction of child/spousal support but excluding In-kind Income and OASDI Benefits on the appropriate WILLIAMS Income Computation Worksheet and enter the amount of net nonexempt income in E. When any of the amounts in B - E change, continue the computation in the next Section. Complete as many Sections (or pages) as necessary to cover the entire period claimed.*

SECTION_____ *(Fill in section number)*

(CHECK ONE)

A. FROM: ____ / ____ (MONTH / YEAR) Through ____ / ____ (MONTH / YEAR) = ____ (NUMBER) Months ☐ Monthly Amounts ☐ Annual Amounts

B. Maximum Aid Payment for ____ (NUMBER) Persons ..... $____

C. Total In-kind Income ..... $____

D. OASDI Benefits Available in Cash (from Notice/Claim Form) ..... $____

E. Other Net Nonexempt Income (from Appropriate Income Computation Worksheet) ..... $____

F. Total Net Nonexempt Income (C + D + E) ..... − ____

G. Retroactive Grant (B — F) ..... =$____

H. 1. If Monthly Amounts, ____ (NUMBER) Months in "A" x $ ____ ("G") = $____ (TOTAL) (Enter This Amount in "I".)

2. If Annual Amount, Enter Amount from "G" in "I".

I. TOTAL PAYMENT FOR TIME PERIOD ..... $____

SECTION_____ *(Fill in section number)*

(CHECK ONE)

A. FROM: ____ / ____ (MONTH / YEAR) Through ____ / ____ (MONTH / YEAR) = ____ (NUMBER) Months ☐ Monthly Amounts ☐ Annual Amounts

B. Maximum Aid Payment for ____ (NUMBER) Persons ..... $____

C. Total In-kind Income ..... $____

D. OASDI Benefits Available in Cash (from Notice/Claim Form) ..... $____

E. Other Net Nonexempt Income (from Appropriate Income Computation Worksheet) ..... $____

F. Total Net Nonexempt Income (C + D + E) ..... − ____

G. Retroactive Grant (B — F) ..... =$____

H. 1. If Monthly Amounts, ____ (NUMBER) Months in "A" x $ ____ ("G") = $____ (TOTAL) (Enter This Amount in "I".)

2. If Annual Amount, Enter Amount from "G" in "I".

I. TOTAL PAYMENT FOR TIME PERIOD ..... $____

SECTION_____ *(Fill in section number)*

(CHECK ONE)

A. FROM: ____ / ____ (MONTH / YEAR) Through ____ / ____ (MONTH / YEAR) = ____ (NUMBER) Months ☐ Monthly Amounts ☐ Annual Amounts

B. Maximum Aid Payment for ____ (NUMBER) Persons ..... $____

C. Total In-kind Income ..... $____

D. OASDI Benefits Available in Cash (from Notice/Claim Form) ..... $____

E. Other Net Nonexempt Income (from Appropriate Income Computation Worksheet) ..... $____

F. Total Net Nonexempt Income (C + D + E) ..... − ____

G. Retroactive Grant (B — F) ..... =$____

H. 1. If Monthly Amounts, ____ (NUMBER) Months in "A" x $ ____ ("G") = $____ (TOTAL) (Enter This Amount in "I".)

2. If Annual Amount, Enter Amount from "G" in "I".

I. TOTAL PAYMENT FOR TIME PERIOD ..... $____

J. **TOTAL RETROACTIVE PAYMENT**
(Enter amounts from I above.)

Section # ____	$____
Section # ____	$____
Section # ____	$____
TOTAL	$____

E.W. SIGNATURE AND DATE	SUPERVISOR SIGNATURE AND DATE

WILLIAMS V. WOODS

INCOME COMPUTATION WORKSHEET — **BEFORE** DECEMBER 1, 1981

CLAIMANT NAME	CASE NUMBER

INSTRUCTIONS: Compute net nonexempt income and enter amount from #10 below in Item E of Worksheet B using Section for corresponding claim period. Compute net nonexempt income on a monthly or annual basis depending on the nature of information provided by the claimant. If monthly amounts are used on Worksheet B for corresponding section, use monthly amounts to compute net nonexempt income. If annualized amounts (or portion thereof) are used on Worksheet B for corresponding section, use annualized amounts (or portion thereof) to compute net nonexempt income.

	SECTION # _____	SECTION # _____	SECTION # _____
	(CHECK ONE) ☐ MONTHLY AMOUNTS ☐ ANNUAL AMOUNTS FROM: ___/___ MO YR THROUGH: ___/___ MO YR NUMBER OF MONTHS_____	(CHECK ONE) ☐ MONTHLY AMOUNTS ☐ ANNUAL AMOUNTS FROM: ___/___ MO YR THROUGH: ___/___ MO YR NUMBER OF MONTHS_____	(CHECK ONE) ☐ MONTHLY AMOUNTS ☐ ANNUAL AMOUNTS FROM: ___/___ MO YR THROUGH: ___/___ MO YR NUMBER OF MONTHS_____
1. Gross earned income for all members of assistance unit.	$	$	$
2. a. If monthly, minus $30; or	—	—	—
b. If annualized, minus $30 x _____ (NUMBER) months in time period.	—	—	—
3. Minus 1/3 of subtotal	—	—	—
4. Minus mandatory deductions (For example: Income Tax, FICA and Retirement, Unemployment and Disability Insurance).	—	—	—
5. Minus actual work-related expenses: (specify)			
_____	—	—	—
_____	—	—	—
_____	—	—	—
_____	—	—	—
6. Minus child care expenses.	—	—	—
7. **SUBTOTAL** (Net Earnings)	=	=	=
8. Plus unearned income. Do not list OASDI and In-Kind Income: (specify)			
_____	+ _____	+ _____	+ _____
_____	+ _____	+ _____	+ _____
_____	+ _____	+ _____	+ _____
9. Minus court-ordered child/spousal support paid	—	—	—
10. **NET NONEXEMPT INCOME**	= $	= $	= $

COMMENTS:

WILLIAMS V. WOODS

INCOME COMPUTATION WORKSHEET — **ON OR AFTER** DECEMBER 1, 1981

CLAIMANT NAME	CASE NUMBER

INSTRUCTIONS: Compute net nonexempt income and enter amount from #11 below in Item E on Worksheet B using Section for corresponding claim period. Compute net nonexempt income on a monthly or annual basis depending on the nature of information provided by the claimant. If monthly amounts are used on Worksheet B for corresponding section, use monthly amounts to compute net nonexempt income. If annualized amounts (or portion thereof) are used on Worksheet B for corresponding section, use annualized amounts (or portion thereof) to compute net nonexempt income.

**This worksheet assumes only 1 assistance unit member with earnings. If more than 1 member has earnings, use additional Section(s) to compute net nonexempt income for additional member(s) and total #11 for all members of the assistance unit before transferring net income to Item E on Worksheet B.*

	SECTION # _____	SECTION # _____	SECTION # _____
	(CHECK ONE) ☐ MONTHLY AMOUNTS ☐ ANNUAL AMOUNTS FROM: ___/___ MO YR THROUGH: ___/___ MO YR NUMBER OF MONTHS_____	(CHECK ONE) ☐ MONTHLY AMOUNTS ☐ ANNUAL AMOUNTS FROM: ___/___ MO YR THROUGH: ___/___ MO YR NUMBER OF MONTHS_____	(CHECK ONE) ☐ MONTHLY AMOUNTS ☐ ANNUAL AMOUNTS FROM: ___/___ MO YR THROUGH: ___/___ MO YR NUMBER OF MONTHS_____
1. Gross earned income for 1 member	$	$	$
2. Minus Income Tax, Social Security, and Disability Insurance	—	—	—
3. Standard Work Expense Disregard	—	—	—
4. Dependent Care Expense Disregard	—	—	—
5. Number of months $30 plus 1/3 disregard allowable.....	( )	( )	( )
6. a. If monthly, minus $30 (only for number of months in 5); or	—	—	—
b. If annualized, minus $30 x _____ months in 5. ..... (NUMBER)	—	—	—
7. **SUBTOTAL**	=	=	=
8. a. If monthly, minus 1/3 of Subtotal (only for number of months in 5); or	—	—	—
b. If annualized, minus 1/3 of portion of subtotal (Subtotal ÷ total number of months earnings covered x number of months in 5)	—	—	—
9. Plus unearned income. Do not list OASDI and In-Kind Income: (specify) _____ _____ _____	+ + +	+ + +	+ + +
10. Minus court-ordered child/spousal support paid	—	—	—
11. **NET NONEXEMPT INCOME**	= $	= $	= $

State of California
Health and Welfare Agency
Department of Social Services

Send one copy to:
Department of Social Services
Statistical Services Branch
744 P Street, M/S 12-81
Sacramento, CA 95814

STATISTICAL REPORT - WILLIAMS v. WOODS

County	/__/ FIRST REPORT	/__/ SECOND REPORT
REPORT PERIOD...	June 1, 1984-November 30, 1984	December 1, 1984-December 31, 1984
DUE DATE.....	December 12, 1984	January 7, 1984

1. Number of claims received..... _____

2. Number of claims approved (in full or in part)..... _____

3. Number of claims denied..... _____

4. Number of claims pending disposition on November 30, 1984 (Item 1 minus Items 2 and 3)..... _____

5. Total retroactive benefits paid..... $_____

Instructions

The second report is for the purpose of reporting the disposition of pending claims reported in Item 4 on the first report. Only those counties that had claims pending on November 30, 1984 are required to submit the second report.

Questions concerning this report should be directed to the Statistical Services Branch at (916) 322-2230 or ATSS 492-2230.

Person to contact regarding this report	Telephone Number ( )	Date