STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814
(916) 445-6907

April 24, 1985

ALL COUNTY LETTER NO. 85-47

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: REVISED FOOD STAMP FORMS: THE DFA 285-A2 APPLICATION FOR FOOD STAMPS - PART 2 (6/85) AND DFA 842 CLAIM DETERMINATION WORKSHEET (2/85)

REFERENCE: ALL-COUNTY LETTER NO. 84-37, DATED MARCH 19, 1984

This letter is to provide information concerning implementation of the revised Application for Food Stamps - Part 2, DFA 285-A2 (6/85) and the Claim Determination Worksheet, DFA 842 (2/85). This letter also transmits advance copies of each of these newly revised forms. Instructions for the DFA 285-A2 (6/85) will be provided under separate cover by May 15, 1985. A copy of the Spanish version of the DFA 285-A2 (6/85) will be provided when available.

Attachments identify the changes to the DFA 842 (2/85), provide revised instructions for the DFA 842 (2/85), and outline the major changes to the DFA 285-A2 (6/85). The forms and their instructions will be incorporated into the Food Stamp Program Forms Handbook, Chapter 63-1200 within the next few months. The form - specific modification criteria for the DFA 285-A2 and DFA 842 in Handbook Section 63-1251 of December 1983 have not been revised.

Implementation

DFA 285-A2 (6/85): All counties will be required to use the revised DFA 285-A2 effective June 1, 1985. All existing approvals to use county-developed forms in place of the 12/83 revision are rescinded when the revised DFA 285 (6/85) is implemented. All existing (12/83) stock should not be used after May 31, 1985.

DFA 842 (2/85): All counties are instructed to continue using the (6/81) stock until that stock is depleted.

Printing County Forms

For those counties printing their own stock, the attached copy of the DFA 285-A2 (6/85) and the DFA 842 (2/85) may be used as masters. As stated above, a copy of the Spanish version of DFA 285-A2 will be sent

when it is available. Those counties requiring translations of the DFA 285-A2 (6/85) in languages other than Spanish should contact Jeanne Rodriquez, Manager, Language Services Unit, at (916) 323-9562.

Ordering

Orders for the English and Spanish DFA 285-A2 (6/85) and the DFA 842 (2/85) should be submitted on the GEN 727B, County Forms Order, according to normal procedures. Supplies of the English version of the DFA 285-A2 (6/85) will be shipped by the DSS Warehouse during the week of May 22, 1985. To ensure that orders for the revised DFA 285-A2 are not filled with existing (12/83) stock, please specify on the order form the (6/85) revision date on the order form. Please submit your orders to the DSS Warehouse by May 13, 1985.

NOTE: Also, please limit your initial order of the DFA 285-A2 (6/85) to a three (3) months' supply. Additional stock, which will be available on July 15, 1985, may be ordered the week of July 1.

The DSS Warehouse will start shipping orders for the DFA 842 (2/85) stock when the current (6/81) stock is depleted.

Should you have any questions, please contact Elizabeth Allred, Food Stamp Forms Coordinator at (916) 445-0316.

Sincerely,

ROBERT A. HOREL
Deputy Director

Attachment

cc: CWDA

DFA 285-A2, Application for Food Stamps - Part 2

The DFA 285-A2 is Part 2 of the food stamp application form completed by all households when first applying for food stamps and at recertification. Part 2 is used to gather information to determine the household's eligibility for food stamps. The application also contains information for the household concerning hearing rights, reporting responsibilities, the penalty warnings, and the certification. In addition the application informs the household that repayment of benefits is required for any overissuance of benefits which occurred from the reporting of incorrect or incomplete information.

The Application for Food Stamps - Part 2 contains the following major changes:

1. The County Use Only Section on Page 1 is revised as follows:

   - Work exemption codes now parallel the order stated in the regulations 63-407.21a-j.

   - The nonhousehold member code section has a new heading "Non-Household/Excluded Members Codes (63-402)". Also, the codes, which are in a new order, include their corresponding regulation code section.

2. Question 2B has been added to identify individuals who have been disqualified from participating in the Food Stamp Program.

3. A third sentence is added to Question 3 informing the applicant/recipient that a noncitizen who does not show proof of eligible alien status will be ineligible for food stamps.

4. The Social Security Number footnote now begins with the statement, "Any person who does not provide a social security number will be disqualified from receiving food stamps".

5. Questions 4 - 9 are in a new order.

6. Question 6 is revised to request unemployment information during the last 90 days. However, there is <u>no change</u> to the 60-day voluntary quit provisions.

7. The narrative in Question 9 is revised to include the phrase, "disabled spouse of a veteran".

8. In Question 13 the term "licensed group home" is changed to "group living arrangements".

9. The heading "SPONSORED ALIENS" is added to Question 14.

10. The narratives in Questions 16A and 16C are revised to make the questions more readily understood by the applicant.

11. The narrative to Question 19 is revised to ask the applicant: "Do you pay for any of the utilities below separately from your rent or mortgage?".

12. The narrative to "YOUR RIGHTS AS AN APPLICANT OR RECIPIENT" is revised as follows:

    - To reflect county intake for state hearing request.

    - To inform the applicant of his/her right "to represent yourself at a state hearing or to be represented by a household member, friend, attorney, or any other person."

13. The narrative to "PENALTY WARNING" is revised to specify the disqualification penalties for Intention Program Violation.

14. The narrative to "YOUR CERTIFICATION" is revised to incorporate wording to inform the household that repayment of benefits is necessary if the applicant, another household member, or authorized representative reports incorrect or incomplete information that results in an overissuance of food stamp benefits.

State of California
Health and Welfare Agency

Department of Social Services

APPLICATION FOR FOOD STAMPS - PART 2

IMPORTANT: SEE PAGE 5 FOR INFORMATION CONCERNING YOUR RIGHTS AND RESPONSIBILITIES.

INSTRUCTIONS: Please complete the following questions in ink. Answer the questions honestly and completely. You may complete this form at home and mail it or bring it to the Food Stamp Office. Another member of your household or an adult who knows you may complete and return it to us. If it is completed by an adult who is not a member of your household, attach a written authorization signed by the head of household or another household member. **IF YOU NEED MORE SPACE, ATTACH ANOTHER SHEET OF PAPER.**

COUNTY USE ONLY

CASE NUMBER

WORKER | DATE RECEIVED

☐ NEW APPLICATION
☐ RECERTIFICATION

EXPEDITED SERVICE ☐ Yes ☐ No

DOCUMENTATION GUIDELINES
Identity, residency, SSN, alien status, 60 or over, disabled

(1) NAME (HEAD OF HOUSEHOLD):

ADDRESS: NUMBER, STREET, ROUTE NUMBER | CITY | STATE | ZIP CODE

MAILING ADDRESS (IF DIFFERENT)

(2) A. Has anyone living in the home received food stamps this month or the previous month? IF YES, WHERE? ☐ YES ☐ NO

B. Have you or anyone in your home been found to have committed Intentional Program Violation or signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement? ☐ YES ☐ NO

(3) Provide the following information on each person living in the home, including yourself. You must list all people in the home whether or not they want food stamps. For each person who is not a citizen, you must provide verification of alien status. (Any non-citizen who does not show proof of eligible alien status will not be eligible for food stamps.)

				Work Registration Information or Non-Household Member Code
1 NAME (HEAD OF HOUSEHOLD)		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *			CIRCLE SEX M F	
2 NAME		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *	RELATIONSHIP TO HEAD OF HOUSEHOLD		CIRCLE SEX M F	
3 NAME		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *	RELATIONSHIP TO HEAD OF HOUSEHOLD		CIRCLE SEX M F	
4 NAME		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *	RELATIONSHIP TO HEAD OF HOUSEHOLD		CIRCLE SEX M F	
5 NAME		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *	RELATIONSHIP TO HEAD OF HOUSEHOLD		CIRCLE SEX M F	
6 NAME		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *	RELATIONSHIP TO HEAD OF HOUSEHOLD		CIRCLE SEX M F	
7 NAME		BIRTHDATE / /	U.S. CITIZEN ☐ YES ☐ NO	
SOCIAL SECURITY NUMBER *	RELATIONSHIP TO HEAD OF HOUSEHOLD		CIRCLE SEX M F	

Work Exemption Codes (63-407.21)

a. Under 18/60 or older
b. Mentally/physically disabled
c. WIN registered
d. Cares for child under 12 or incapacitated person
e. Cares for child under 18 and HH member reg/emp
f. UIB registered
g. Participant in drug/alcohol program
h. 30 hour week/min. x 30
i. Meets eligible student criteria
j. GA, non-WIN PA, or Refugee Resettlement Program registered

☐ DFA 285-C

Non-Household/Excluded Member Codes (63-402)

1. Separate household (.12, .13) (Purchase/prepared)
2. Separate Household (.15) (Elderly/disabled)
3. Roomer (.211)(must be listed in 12).
4. Live-in attendant (.212)
5. SSI/SSP recipient (.213)
6. Ineligible student (.214)
7. Other (.215) (Shared living quarters)
8. Ineligible alien (.221)
9. Boarder (.3)(must be listed in 12).
10. SSN disqualified (.222)
11. IPV disqualified (.223)
12. Workfare sanctioned (.224)
13. Questionable citizenship (403.312)

(4) Does anyone purchase or prepare meals separately from others in the home? ☐ YES ☐ NO
IF YES, WHO? WHEN?

(5) Is anyone currently on strike? ☐ YES ☐ NO
IF YES, WHO?

Date household member went on strike: _____

(6) Has anyone become unemployed in the last 90 days? ☐ YES ☐ NO
IF YES, WHO? WHEN?

Vol. Quit: ☐ Yes ☐ No

(7) Has anyone sold, traded, or given away anything of value in the last 3 months? ☐ YES ☐ NO
IF YES, EXPLAIN WHO AND WHAT:

Household Size: _____

* Any person that does not provide a social security number will be disqualified from receiving food stamps. Disclosure of a Social Security Number (SSN) is required by the Food Stamp Act of 1977, as amended by Public Law 97-98, for each food stamp household member. These SSNs will be used to check identity, prevent duplicate participation and to make changes. The SSNs and any other information provided, will also be used in computer matching and program reviews or audits to ensure issuance of benefits to eligible individuals participating in the Food Stamp Program or other federal assistance programs; such as: school lunch, Cash Aid or Medi-Cal. Fraudulent participation in the Food Stamp Program may result in criminal or civil action or administrative claims.

(8) Is anyone participating in a Food Distribution Program operated by an Indian Reservation? ☐ YES ☐ NO
IF YES, WHO?

(9) Is anyone a disabled veteran, or a disabled spouse of a veteran or a child of a deceased veteran? ☐ YES ☐ NO
IF YES, WHO?

(10) Is anyone age 60 or older and unable to purchase and prepare meals separately because of a disability? ☐ YES ☐ NO
IF YES, WHO?

(11) Is anyone a student 18 or over who attends college or career training? ☐ YES ☐ NO
IF YES, COMPLETE THE FOLLOWING:

NAME OF STUDENT	SCHOOL OR PROGRAM	NO. OF CLASS HOURS PER WEEK/UNITS
1.		
2.		

(12) **ROOMERS AND BOARDERS**

A. Does anyone pay you for meals and/or a room? IF YES, COMPLETE THE FOLLOWING: ☐ YES ☐ NO

NAME		HOW MUCH?	HOW OFTEN?	NO. OF MEALS PER DAY
1.	☐ MEALS ☐ ROOM ☐ BOTH	$		
2.	☐ MEALS ☐ ROOM ☐ BOTH	$		

B. Do you pay someone else for meals and/or a room? IF YES, COMPLETE THE FOLLOWING: ☐ YES ☐ NO

NAME		HOW MUCH?	HOW OFTEN?	NO. OF MEALS PER DAY
1.	☐ MEALS ☐ ROOM ☐ BOTH	$		
2.	☐ MEALS ☐ ROOM ☐ BOTH	$		

(13) **INSTITUTIONS:** Do you currently live in one of the following institutions?

Drug/alcohol rehabilitation center ☐ YES ☐ NO
Shelter for battered women ☐ YES ☐ NO
Federally subsidized housing for the elderly ☐ YES ☐ NO
Other ☐ YES ☐ NO
Group living arrangement for the disabled/blind ☐ YES ☐ NO

IF YES, TO ANY OF THE ABOVE, GIVE NAME OF HOME/CENTER:

(14) **SPONSORED ALIENS:**
Does anyone who is not a U.S. citizen have a sponsor? ☐ YES ☐ NO
IF YES, WHO HAS A SPONSOR?

(15) **RESOURCES** DO NOT COMPLETE ITEM 15 IF EVERYONE IN THE HOME RECEIVES AFDC.

A. Does anyone have any of the resources listed below? YOU MUST CHECK EACH ITEM YES OR NO. If YES, complete the additional information needed. Do not include your home, household goods, cash value of life insurance policies or personal items (books, clothes, etc.).

	(✓) YES	(✓) NO	Household Member Who Has This Resource	Current Value	Amount Owed	Income Producing YES	Income Producing NO	(✓) If exempt
1. Checks or money (at home or elsewhere)	☐	☐		$				
2. Checking account	☐	☐		$				
3. Savings account/credit union account	☐	☐		$				
4. Real estate (other than home)	☐	☐		$	$			
5. Notes, mortgages, trust deeds, sales contracts	☐	☐		$	$			
6. Trust funds	☐	☐		$				
7. Stocks, bonds, certificates	☐	☐		$				
8. Pension funds (specify)	☐	☐		$				
9. Other (specify)	☐	☐		$	$			

B. Does anyone own any cars, trucks, boats, trailers, vans, campers, motorcycles or other vehicles? ☐ YES ☐ NO
IF YES, COMPLETE THE FOLLOWING FOR EACH VEHICLE. Look at your registration to find the information for each vehicle you own.

Vehicles	Vehicle (1)	Vehicle (2)	Vehicle (3)
Vehicle Owner			
Year/Class			
Make and Model			
Estimated Value			
Amount Owed			
Licensed (✓ box)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

COUNTY USE ONLY

Separate household requested: ☐ Yes ☐ No

Eligible Student
1. ☐ Yes ☐ No
2. ☐ Yes ☐ No

Household Elects	BOARDER	HH MEMBER	ROOMER

Eligible Institution ☐ Yes ☐ No

Vehicle Valuation
(Enter date of blue book issue or other documentation)
(1) _____
(2) _____
(3) _____

Total Resources
$ _____

Resource Eligible: ☐ Yes ☐ No

COUNTY USE ONLY - VEHICLES

(A)	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)
Home, income producing or handicap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Under $4500 per table?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Exempt? For H.H. use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Work, seek work, school, training?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If exempt and under $4500 STOP here; do not go to (B)

(B) Values

	( )	( )
FMV		
Minus $4500		
Excess Value		
FMV		
Minus Encumbrance		
Equity Value		

(16) INCOME

COUNTY USE ONLY

DOCUMENTATION GUIDELINES

Verify all income and list type of documentation viewed. Note exempt sources of income. Note dates of all pay stubs viewed.

A. WAGES

You must give us wage and income information on any person(s) in the home who work(s) full or part-time. List any person who has recently stopped working or has started working but has not received any wages yet. If a person has more than one job, list each job separately. Also, list any person who receives income from work study, CETA, WIN or any other training program. For your interview, please bring pay stubs or other proof of wages.

HOUSEHOLD MEMBER WHO RECEIVES THIS INCOME	NAME OF EMPLOYER	(✓) If Income Expected	(✓) If Income Stopped	(✓) How Often Paid: Weekly	Every 2 Weeks	Twice Monthly	Monthly	Gross Amount (Total Before Deductions)	(✓) If Exempt
1.									
2.									
3.									
4.									

B. SELF-EMPLOYMENT Is anyone in your household self-employed? ☐ YES ☐ NO

IF YES, WHO?

You must provide proof of self-employment costs and income.

C. OTHER INCOME Has any person received income from any of the sources listed below?

Complete even if income has recently stopped or if anyone has applied for or expects to receive income from any of these sources. CHECK EACH ITEM YES OR NO. If YES, complete the additional information needed. For your interview, bring proof of income for which you have checked YES below.

SOURCE OF INCOME	(✓) YES	(✓) NO	IF YES, HOUSEHOLD MEMBER WHO RECEIVES THIS INCOME	(✓) If Income Expected	(✓) If Income Stopped	(✓) How Often Received: Weekly	Every 2 Weeks	Twice Monthly	Monthly	Amount of Each Check or Payment	(✓) If Exempt
1. AFDC (Aid to Families with Dependent Children) or RCA/ECA (Refugee/Entrant Cash Assistance)	☐	☐									
2. Social Security-Blue/Green Checks	☐	☐									
3. SSI (Supplemental Security Income) - Gold Checks	☐	☐									
4. GA (General Assistance) or GR (General Relief)	☐	☐									
5. VA (Veterans Benefits)	☐	☐									
6. UIB or DIB (Unemployment or Disability Insurance Benefits) or Worker's Compensation	☐	☐									
7. Pensions or Retirement Income	☐	☐									
8. A. Grants, Loans, Scholarships, for school B. Tuition, Fees $	☐	☐									
9. Child and/or Spousal Support	☐	☐									
10. Money from other persons (other than loans)	☐	☐									
11. Loans	☐	☐									
12. Gross Income from Property	☐	☐									
13. Other (specify)	☐	☐									

COUNTY USE ONLY

Gross Income Test

Household Size _____

Gross Monthly Income $ _____

Gross Income Eligible: ☐ Yes ☐ No ☐ N/A

Separate Household Income Test

Household Size _____

Gross Monthly Income $ _____

Eligible for Separate Household Status: ☐ Yes ☐ No

(17) **DEPENDENT CARE:** Does anyone pay for someone to care for a child or disabled adult so that a member can work, attend training or look for a job? ☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

NAME OF PERSON PROVIDING THE CARE	WHO PAYS?	HOW MUCH DO YOU PAY?	HOW OFTEN?

(18) **HOUSING COSTS**

Complete the amount and how often you are billed for each of the housing costs you have.

HOUSING COSTS	AMOUNT	HOW OFTEN?
A. Rent	$	
B. Mortgage Payment	$	
C. Property Taxes (if not included in mortgage payment)	$	
D. Insurance On Home (if not included in mortgage payment)	$	
E. Other Housing Costs (specify)	$	

(19) **UTILITIES:** Do you pay for any of the utilities listed below separately from your rent or mortgage? CHECK YES OR NO FOR EACH LISTED UTILITY. If yes, list the amount you are billed and how often you are billed. If you qualify for the state Standard Utility Allowance (SUA) you may ask the county to use the SUA in computing your benefits. However, if your utility bills are higher than the SUA, you may receive more food stamps. Bring verification for any amounts listed below.

UTILITIES	(✓) YES	(✓) NO	AMOUNT	HOW OFTEN?
A. Gas or Fuel (for heating or cooling)	☐	☐	$	
B. Electricity (for heating or cooling)	☐	☐	$	
C. Gas or Electricity or Other Fuel (for cooking)	☐	☐	$	
D. Water	☐	☐	$	
E. Sewage	☐	☐	$	
F. Garbage or Trash	☐	☐	$	
G. Telephone (basic rate)	☐	☐	$	
H. Installation of Utilities	☐	☐	$	
I. Other (specify)	☐	☐	$	

(20) Does anyone pay or help you pay any of the housing or utility bills you have listed in (18) or (19) above? ☐ YES ☐ NO

IF YES, EXPLAIN:

(21) Is anyone living in the home a farmworker who is currently away from his/her own home to work or to look for work? ☐ YES ☐ NO

IF YES, WHO?

(22) The law requires that information on ethnic origin and primary language be collected. However, the information will not affect your eligibility for food stamps. If you do not wish to complete this section the eligibility worker will make this judgment.

My ethnic group is (check one box only):

- WH ☐ White (not of Hispanic origin)
- H ☐ Hispanic
- B ☐ Black (not of Hispanic origin)
- AP ☐ Asian or Pacific Islander
- AI ☐ American Indian or Alaskan Native
- F ☐ Filipino

My language is (check one box only): (If you can speak and understand English, check English.)

- E ☐ English
- SP ☐ Spanish
- C ☐ Chinese
- V ☐ Vietnamese
- F ☐ Filipino (Tagalog)
- S ☐ Sign
- O ☐ Other (specify)

(23) Does anyone receive meals from:

A. Meals on Wheels Program ☐ YES ☐ NO

B. Communal Dining Facility ☐ YES ☐ NO

(24) You can authorize someone outside your household to pick up your food stamps for you or to use them to buy your food. If you would like to authorize someone, complete below.

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	TELEPHONE NUMBER

COUNTY USE ONLY

Verify all housing costs.

Total Housing $ _____

Client Elects:

☐ Actual ☐ SUA

Verify client utilities.

Total Utilities $ _____

SUA Prorated:

☐ Yes ☐ No

Exempt from retrospective budgeting:

☐ Yes ☐ No

ETHNIC ORIGIN			
WH	H	B	AP
1	2	3	4
AI	F		
5	7		

PRIMARY LANGUAGE			
E	SP	CH	
7	1	2	
V	F	S	O
3	4	5	6

IMPORTANT INFORMATION — READ CAREFULLY

YOUR RIGHTS AS AN APPLICANT OR RECIPIENT:

- To be served without regard to race, color, national origin, religion, political affiliation, sex, handicap, or age; and to file a complaint should you feel you have been discriminated against.
- To discuss any action regarding your case with the County Welfare Department any time you are dissatisfied.
- To request a state hearing within 90 days if you are dissatisfied with any action taken by the County Welfare Department.
- To file a complaint or request a state hearing by writing to your local County Welfare Department or by calling toll free 1-800-952-5253. The toll free number for the deaf (TDD) is 1-800-952-8349.
- To represent yourself at a state hearing or be represented by a household member, friend, attorney, or any other person.

YOUR RESPONSIBILITIES AS AN APPLICANT OR RECIPIENT:

- To provide documents to confirm the information on this application. If documents are not available, to give the name of a person or organization the food stamp office may contact to obtain the necessary verification.
- To cooperate fully with county, state and federal personnel in a quality control review.

☐ **MONTHLY REPORTING HOUSEHOLDS**

- To file a complete monthly report (CA 7) by the 5th day of the month.
- To provide any additional information or verification requested by the County Welfare Department as a result of information you report on the CA 7.

☐ **NONMONTHLY REPORTING HOUSEHOLDS**

- To notify the County Welfare Department as soon as, but no later than 10 days, from the time you learn of any of the following changes:
  - The gross monthly income received by your household increases or decreases by more than $25.
  - The source of any income received by you or any member of your household changes.
  - You change your address.
  - There are any changes in housing or utility costs because you move.
  - Anyone moves in or out of your home.
  - The property owned by you or any member of your household changes; for example, you acquire a licensed vehicle, or the total of your household's stocks, bonds, or other money reaches or exceeds $1500.
  - There is an increase or decrease of more than $25 in medical expenses for a household member who is disabled or age 60 or older.
- To report any changes to the County Welfare Department by telephone, by mail or by coming into the food stamp office.
- To meet the reporting responsibilities for the AFDC or Refugee/Entrant Cash Aid Programs if you receive cash aid as well as food stamps.

If you have any doubt about needing to report any change, contact your worker. If you fail to report a change and because of this you receive food stamp benefits you are not entitled to, you will have to repay them.

PENALTY WARNING:

IF YOUR HOUSEHOLD RECEIVES FOOD STAMPS, IT MUST FOLLOW THE RULES LISTED BELOW. FAILING TO REPORT INFORMATION OR MISREPRESENTATION OF FACTS CAN RESULT IN LEGAL PROSECUTION WITH PENALTIES OF A FINE, IMPRISONMENT OR BOTH. THE PENALTIES CAN RESULT IN DISQUALIFICATION FROM THE PROGRAM, FINES UP TO $10,000 OR IMPRISONMENT FOR UP TO 5 YEARS. THE DISQUALIFICATION PENALTIES ARE 6 MONTHS FOR THE FIRST VIOLATION, 12 MONTHS FOR THE SECOND VIOLATION, AND PERMANENT DISQUALIFICATION FOR THE THIRD VIOLATION.

- Do not give false information or withhold information to get or continue to get food stamps.
- Do not trade or sell food stamps or Authorization to Participate cards (ATPs).
- Do not alter ATPs to get food stamps you are not entitled to receive.
- Do not use food stamps to buy ineligible items such as alcoholic drinks and tobacco.
- Do not use someone else's food stamps or ATPs for your household.

YOUR CERTIFICATION

- *I certify that I understand the questions on the application and that I have read the above Penalty Warning (or had it read to me), and that I understand my responsibilities. I understand that the information that I have provided will be verified by local, state and federal personnel. I also understand that I may be required to repay any benefits which are overpaid because I, another household member, or the authorized representative reports incorrect or incomplete information. I also understand that if any of this information is found to be incorrect, I may be disqualified from the Program and subject to criminal prosecution if anyone knowingly provides false information. I further understand the penalties for breaking any of the rules listed above.*

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

I certify that I have informed the applicant/recipient of the above responsibilities and of the possibilities of criminal penalties for intentionally making false statements or failing to report information which affects food stamp eligibility.

SIGNATURE OF INTERVIEWING WORKER ▶	DATE APPLICATION REVIEWED WITH CLIENT OR AUTHORIZED REPRESENTATIVE

IMPORTANT INFORMATION — READ CAREFULLY

YOUR RIGHTS AS AN APPLICANT OR RECIPIENT:

- To be served without regard to race, color, national origin, religion, political affiliation, sex, handicap, or age; and to file a complaint should you feel you have been discriminated against.
- To discuss any action regarding your case with the County Welfare Department any time you are dissatisfied.
- To request a state hearing within 90 days if you are dissatisfied with any action taken by the County Welfare Department.
- To file a complaint or request a state hearing by writing to your local County Welfare Department or by calling toll free 1-800-952-5253. The toll free number for the deaf (TDD) is 1-800-952-8349.
- To represent yourself at a state hearing or be represented by a household member, friend, attorney, or any other person.

YOUR RESPONSIBILITIES AS AN APPLICANT OR RECIPIENT:

- To provide documents to confirm the information on this application. If documents are not available, to give the name of a person or organization the food stamp office may contact to obtain the necessary verification.
- To cooperate fully with county, state and federal personnel in a quality control review.

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- To provide any additional information or verification requested by the County Welfare Department as a result of information you report on the CA 7.

☐ **NONMONTHLY REPORTING HOUSEHOLDS**

- To notify the County Welfare Department as soon as, but no later than 10 days, from the time you learn of any of the following changes:
  - The gross monthly income received by your household increases or decreases by more than $25.
  - The source of any income received by you or any member of your household changes.
  - You change your address.
  - There are any changes in housing or utility costs because you move.
  - Anyone moves in or out of your home.
  - The property owned by you or any member of your household changes; for example, you acquire a licensed vehicle, or the total of your household's stocks, bonds, or other money reaches or exceeds $1500.
  - There is an increase or decrease of more than $25 in medical expenses for a household member who is disabled or age 60 or older.
- To report any changes to the County Welfare Department by telephone, by mail or by coming into the food stamp office.
- To meet the reporting responsibilities for the AFDC or Refugee/Entrant Cash Aid Programs if you receive cash aid as well as food stamps.

If you have any doubt about needing to report any change, contact your worker. If you fail to report a change and because of this you receive food stamp benefits you are not entitled to, you will have to repay them.

PENALTY WARNING:

IF YOUR HOUSEHOLD RECEIVES FOOD STAMPS, IT MUST FOLLOW THE RULES LISTED BELOW. FAILING TO REPORT INFORMATION OR MISREPRESENTATION OF FACTS CAN RESULT IN LEGAL PROSECUTION WITH PENALTIES OF A FINE, IMPRISONMENT OR BOTH. THE PENALTIES CAN RESULT IN DISQUALIFICATION FROM THE PROGRAM, FINES UP TO $10,000 OR IMPRISONMENT FOR UP TO 5 YEARS. THE DISQUALIFICATION PENALTIES ARE 6 MONTHS FOR THE FIRST VIOLATION, 12 MONTHS FOR THE SECOND VIOLATION, AND PERMANENT DISQUALIFICATION FOR THE THIRD VIOLATION.

- Do not give false information or withhold information to get or continue to get food stamps.
- Do not trade or sell food stamps or Authorization to Participate cards (ATPs).
- Do not alter ATPs to get food stamps you are not entitled to receive.
- Do not use food stamps to buy ineligible items such as alcoholic drinks and tobacco.
- Do not use someone else's food stamps or ATPs for your household.

YOUR CERTIFICATION

- *I certify that I understand the questions on the application and that I have read the above Penalty Warning (or had it read to me), and that I understand my responsibilities. I understand that the information that I have provided will be verified by local, state and federal personnel. I also understand that I may be required to repay any benefits which are overpaid because I, another household member, or the authorized representative reports incorrect or incomplete information. I also understand that if any of this information is found to be incorrect, I may be disqualified from the Program and subject to criminal prosecution if anyone knowingly provides false information. I further understand the penalties for breaking any of the rules listed above.*

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

I certify that I have informed the applicant/recipient of the above responsibilities and of the possibilities of criminal penalties for intentionally making false statements or failing to report information which affects food stamp eligibility.

SIGNATURE OF INTERVIEWING WORKER ▶	DATE APPLICATION REVIEWED WITH CLIENT OR AUTHORIZED REPRESENTATIVE

DFA 842, Claim Determination Worksheet

The DFA 842 is used to document claims against any household that has received more food stamp benefits than it is entitled to receive. This form has a twofold purpose: 1) completion of the form allows for internal documentation of individual claims, and 2) documentation of individual claims assists counties in gathering information for the monthly report, DFA 209, Status of Claims Against Households.

The Claim Determination Worksheet contains the following changes.

1. Item 9 Basis for Claim Determination is revised to reflect the regulation changes transmitted in ACL 84-37 dated, March 19, 1984. For example: Administrative/Procedural Error is changed to Administrative Error, Household Error is changed to Inadvertent Household Error, and Potential Fraud is changed to Potential IPV.

2. Item 11 Summary of Food Stamp Overissuance narrative "Include on this page only those overissuance months which are within 12 months prior to date of discovery" is deleted.

3. The narrative in Item 14 is revised.

4. Please revise Item 9 instructions in Manual Letter No. 84-13 (Handbook Section 63-1230, DFA 842 (6/81) (Instructions Revised 3/84)) to read as follows:

   (Check Inadvertent Household Error box on form.)
   (Check Administrative Error box on form.)
   (Check Potential Intentional Program Violation (IPV) box on form.)

   Note: No other instructions on completing this form have been changed.

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

CLAIM DETERMINATION WORKSHEET

1. HEAD OF HOUSEHOLD	2. CASE NAME (IF DIFFERENT)	3. CASE NUMBER	
4. ADDRESS		5. TELEPHONE	6. BIRTHDATE
7. SOCIAL SECURITY NUMBER	8. DATE OF DISCOVERY	9. BASIS FOR CLAIM DETERMINATION ☐ ADMINISTRATIVE ERROR ☐ INADVERTENT HOUSEHOLD ERROR ☐ POTENTIAL IPV	

10. EXPLANATION OF OVERISSUANCE (IF APPLICABLE, INCLUDE DATE CHANGE OCCURRED AND DATE REPORTED)

11. SUMMARY OF FOOD STAMP OVERISSUANCE

ISSUANCE	ACTUAL BASIS FOR ISSUANCE			CORRECT BASIS FOR ISSUANCE			ISSUANCE VERIFICATION		
MONTH YEAR	HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	DMI	ATP/HIR	REDEMPTION
Continue on reverse	11a Total ►				11b Total ►				

DOCUMENTATION

12. Total food stamp overissuance (subtotal if continued on reverse) — 11a Minus 11b ►

13. Claim offsetting lost benefits not restored.

	DATE	DATE
A. Total food stamp overissuance (from 12 above).		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of food stamp claim to be collected.		

ELIGIBILITY WORKER SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE

COUNTY REVIEW

ACTION TAKEN:

APPROVED BY (SIGNATURE)	DATE

14 Summary of food stamp overissuance (Continuation) — Include all other overissuance months not listed on the front.

ISSUANCE	ACTUAL BASIS FOR ISSUANCE			CORRECT BASIS FOR ISSUANCE			ISSUANCE VERIFICATION		
MONTH YEAR	HOUSEHOLD SIZE	ADJUSTED INCOME	BONUS ALLOTMENT	HOUSEHOLD SIZE	ADJUSTED INCOME	BONUS ALLOTMENT	DMI	ATP / HIR	REDEMPTION

Total this page	14a Subtotal ►			14d Subtotal ►	
Total first page	14b Subtotal (from 11a) ►			14e Subtotal (from 11b) ►	
Total both pages	14c Total ►			14f Total (14d - 14e) ►	

DOCUMENTATION

15 Total food stamp overissuance — 14c Minus 14f ► _____

16 Claim offsetting against lost benefits not restored.

	DATE	DATE
A Total food stamp overissuance (from 15 above)		
B Minus lost benefits not restored		
C Minus payment received		
D Amount of food stamp claim to be collected		

ELIGIBILITY WORKER SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE

DOCUMENTATION