

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814



October 11, 1994

ALL-COUNTY LETTER NO. 94-86

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

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

SUBJECT: SAWS 2 (9/94), STATEMENT OF FACTS, CASH AID, FOOD STAMPS, AND MEDI-CAL

This letter transmits a copy of the SAWS 2 (9/94), Statement of Facts, Cash Aid, Food Stamps, and Medi-Cal. The SAWS 2 will be used by the Interim SAWS counties for Cash Aid, Food Stamp and Medi-Cal Only cases. Non-SAWS counties have the option of using the SAWS 2 (9/94) for Cash Aid and Food Stamp cases in lieu of the BC JA 2, Statement of Facts, Cash Aid and Food Stamps; and for Food Stamp Only cases, the DFA 285-A2, Application for Food Stamps, Part 2. An attachment to this letter outlines the differences between the SAWS 2 and the BC JA 2.

STOCK

A major change to the SAWS 2 may occur in the next few months. The SAWS 2 will be a Master Only form; no state reproduced stock will be made. Counties are, therefore, advised to limit locally reproduced stock. If such a revision is necessary, counties may not be able to deplete (SAWS 2) 9/94 stock. In January 1995, the California Department of Social Services will advise counties of the status of the SAWS 2 and the date state produced stock can be expected.

TRANSLATIONS

Copies of the Spanish and Asian language versions (Chinese, Lao, Cambodian, and Vietnamese) of the SAWS 2 (9/94) will be forwarded to the County Forms Coordinators by the Language Services Bureau when the translations are available.

CONTACTS:

If you have any questions or need further information, please contact the following staff regarding the specific program areas:

- o SAWS 2 or this letter: Elizabeth Allred (916) 657-3350 or CALNET at 437-3350;

- o the Food Stamp Program: Melissa Buchanan at (916) 654-8467 or CALNET at 464-8467;
- o a camera-ready copy of the SAWS 2: The Forms Management Unit at (916) 657-1984 or CALNET 437-1984;
- o Asian/Spanish translations: Shirley Lu, at (916) 654-1277 or CALNET at 464-1277.

Sincerely,



MICHAEL C. GENEST
Deputy Director
Welfare Programs Division

Attachments

cc: CWDA
Frank Martucci, Department of Health Services

SAWS 2

The SAWS 2 (9/94) integrates questions from the statements of facts for each of the following three programs: Cash Aid, Food Stamps, and Medi-Cal. The following outline identifies significant narrative and format differences between the SAWS 2 (9/94) and the BC JA 2 (11/92). Unless otherwise indicated, the referenced items below refer to the Item number on the SAWS 2, not on the BC JA 2. Routine changes in the County Use Only (CUO) section to annotate the new, revised or deleted items are not discussed.

Pages 1 and 2

- o Narrative for completing Items 2 and 3 was added for Medi-Cal Only (MCO) purposes: "But if you are applying for Restricted Medi-Cal...."
- o The Adult/Child identifying information in Items 2 and 3 were revised:
 - "Citizenship/Immigration Status" was reworded.
 - the "Blind or Disabled" item was revised to "Blind, Deaf or Disabled."
 - the "Pregnant?" status question was added eliminating Item 3, "Is anyone pregnant?" on the BC JA 2. The CUO sections on pages 1 and 2 were revised to incorporate a checkbox for the (completion and forwarding of the) CA 2.1, Questionnaire/Notice and Agreement, and CA 371, Referral to District Attorney. Documentation of the WIC referral was relocated to the "Regulations Met" section on Page 13, as follows: "Pregnancy verified/WIC Referral."
- o In the CUO section in the right column on Pages 1 and 2: "GAIN" [Greater Avenues for Independence] replaced "AFDC" in the "Work Registration/Exemption Codes" section.
- o The CUO section at the bottom of Page 1 has been revised and reformatted:
 - the second column was retitled "FS Work and Training Exemptions."
 - a third column, "GAIN Exemptions," was added. Note: The "GAIN Exemptions" include recent changes identified in All County Letter 94-49 regarding Exemption 08, "Child Under Age 3 (Full)," and Exemption 12, "Care of Child Under Age 3 (Limited)."
- o The CUO section to the right of Item 3 on Page 2 was revised for a new Child Support program regarding the establishment of paternity for the IV-D agency. Effective, January 1, 1995, unmarried parents can voluntarily acknowledge paternity on a state developed form called the "Declaration of Paternity." Under separate cover, the Child Support Branch will release a copy of the Declaration with a transmittal that will provide details of this new program. Note: The CUO section does not need to be completed until January 1995.

Page 3

- o Item 6B adds the FS Only question regarding foster child(ren) and foster care income.
- o Item 8, the question establishing residency in California, was revised.
- o The relocation question (Item 8 on the JA 2) was deleted.

Page 4

- o Item 14, FS Food Distribution Programs, and Item 15, the Out-of-Home Residency question, were reformatted to facilitate completion by the applicant.
- o Item 17 adds Cal-Learn questions regarding pregnancy and teen parenting for assistance unit members under age 19.

Page 5

- o In the CUO section to the right of Item 20A, counties may document "Child Care Informing" for CAAP [California Alternative Assistance Programs], SCC [Supplemental Child Care], or NET [Non-Educational Training].
- o Narrative was added to Item 20B to provide examples of reimbursement for child care costs, such as "costs paid by relative or friend, Department of Education...."
- o Item 23 adds "Gross Monthly Income Earned From This Job Before the Strike."

Page 6

- o New item 25 adds: "Who do you want as the head of your food stamp household?" In the CUO section, "H of H" is an abbreviation for "Head of Household" and "HH" is for "Household."
- o Items 26A and B: "Is He/She a Native American? If 'YES,' List Tribe." In the CUO section, counties can annotate Tribal JOBS Referrals.
- o The table in the CUO section determining the Principal Earner was reformatted.

PAGE 7

- o Item 27 was revised to:
 - reformat the "Social Security Benefits" section.
 - add "(Money for) Medical bills or premiums" to the "Support" section.
 - add "Aid and Attendance" and "VEAP" to the "Veterans Administration" section.
- o The CUO section to the right of Item 27A was revised for the FS program. As outlined in ACL 94-67, new FS regulations exclude the "earned income of children who are elementary or secondary school students at least halftime and who have not attained their 22nd birthday at the beginning of the [FS] budget month."
- o Item 29B was added: "Does anyone own a house which is not lived in now that he/she hopes to return to someday?"
- o On Pages 7, 8 and 9, the CUO sections were revised to document totals for "Countable property" for each program.

PAGE 8

- o Item 30, the resources question, was reformatted to include property items listed in separate questions on the JA 2, such as life insurance and burial plans.
- o Item 31 was added for MCO cases regarding the signing of a lien or a security agreement "as security for health care services."
- o Item 32 was revised:
 - to change bullet two to "guns; tools; business or sporting equipment."
 - to reverse the third and fourth bullets.
 - to add "Pickle Program: \$500+ Limit" to the CUO section (for MCO cases).

PAGES 9, 10, and 11

- o Item 33A: Narrative in the first sentence was revised to read: "Has anyone sold, spent, traded, transferred...." Narrative in the second sentence was revised for MNO cases: "(...and within the last 3 years (36 months) for Medi-Cal)."
- o Item 33B regarding receipt of "money from insurance or court settlements, inheritance, lottery or back pay..." was added for MNO cases.
- o Item 34: The motor vehicle sections completed by the applicant and by the county were reformatted to parallel the format on the DFA 285-A2. Other changes to the CUO section were made to incorporate Medi-Cal documentation needs.
- o Items 35 and 36 were reformatted to parallel the DFA 285-A2 format. The CUO section was modified to include documentation for metering and proration of the SUA [Standard Utility Allowance].
- o Item 43 and, for MCO cases, Item 44B were added to identify and determine the extent of physical or emotional problems in the assistance unit.

PAGE 12

- o Item 45 was reformatted.
- o Item 46 for Child Health and Disability Prevention Program (CHDP) was revised.
- o The "Certification" section was language and format simplified.
- o The primary signature block was revised to read: "Signature (Parent or Caretaker Relative, Medi-Cal Applicant, Food Stamp Household Member or Food Stamp Authorized Representative.)"

PAGE 13

- o Medi-Cal needs were incorporated onto this page.
- o The FS Tests section was reformatted to parallel the DFA 285-A2.

STATEMENT OF FACTS

CASH AID, FOOD STAMPS AND MEDI-CAL

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "FS" for Food Stamps and "MC" for Medi-Cal listed to the left of each question tell you which questions are for each program. If you need more space, attach another sheet.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form.
- If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

COUNTY USE ONLY

CASE NAME _____

CASE NUMBER _____

WORKER _____ DATE RCD _____

New Restoration
 Redetermine Recertification

Residency Verified
 FS ID MC ID
 FS Aged/Disabled Verified

CA **FS** **MC** ① **Name of person applying, or caretaker relative of child(ren) for whom aid is wanted.**

HOME PHONE () _____

HOME ADDRESS (NUMBER, STREET) _____ MAILING ADDRESS (IF DIFFERENT) _____ DAYTIME PHONE () _____

CITY _____ STATE _____ ZIP CODE _____ CITY _____ STATE _____ ZIP CODE _____

② For each **ADULT living in the home**, give us all the facts. **But if you are applying for Restricted Medi-Cal, DO NOT give us any facts in any of the shaded boxes, such as Citizenship/Immigration Status, Social Security Number, and/or Birthplace.**

CA (A) **FS** **MC** APPLICANT'S NAME (FIRST, MIDDLE, LAST) _____ SEX (✓) M F

CITIZENSHIP/IMMIGRATION STATUS (✓)
 U.S. Citizen Refugee PRUCOL
 Lawful Permanent Resident — Sponsored? YES NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE _____ BIRTHDATE / / _____ SOCIAL SECURITY NUMBER _____

BLIND, DEAF OR DISABLED? YES NO PREGNANT? YES NO BIRTHPLACE (CITY/STATE/COUNTRY) _____

SFU (✓) AU (✓) MFBU (✓) FS Non-HH/Excluded Member Code _____

CA 2.1/ CA 371

Work Registration/Exemption Codes:
 GAIN _____ FS _____

TYPE OF AID REQUESTED (✓)
 Cash Aid Food Stamps None
 Full Medi-Cal Restricted Medi-Cal

MARITAL STATUS (✓)
 Married Never Married Separated
 Divorced Common Law Widowed

VERIFIED: Blind/Deaf/Disabled SAVE
 SSN Citizen/Immig.

CA (B) **FS** **MC** ADULT'S NAME (FIRST, MIDDLE, LAST) _____ SEX (✓) M F

CITIZENSHIP/IMMIGRATION STATUS (✓)
 U.S. Citizen Refugee PRUCOL
 Lawful Permanent Resident — Sponsored? YES NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE _____ BIRTHDATE / / _____ SOCIAL SECURITY NUMBER _____

BLIND, DEAF OR DISABLED? YES NO PREGNANT? YES NO BIRTHPLACE (CITY/STATE/COUNTRY) _____

SFU (✓) AU (✓) MFBU (✓) FS Non-HH/Excluded Member Code _____

CA 2.1/ CA 371

Work Registration/Exemption Codes:
 GAIN _____ FS _____

TYPE OF AID REQUESTED (✓)
 Cash Aid Food Stamps None
 Full Medi-Cal Restricted Medi-Cal

MARITAL STATUS (✓)
 Married Never Married Separated
 Divorced Common Law Widowed

VERIFIED: Blind/Deaf/Disabled SAVE
 SSN Citizen/Immig.

CA (C) **FS** **MC** ADULT'S NAME (FIRST, MIDDLE, LAST) _____ SEX (✓) M F

CITIZENSHIP/IMMIGRATION STATUS (✓)
 U.S. Citizen Refugee PRUCOL
 Lawful Permanent Resident — Sponsored? YES NO

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE _____ BIRTHDATE / / _____ SOCIAL SECURITY NUMBER _____

BLIND, DEAF OR DISABLED? YES NO PREGNANT? YES NO BIRTHPLACE (CITY/STATE/COUNTRY) _____

SFU (✓) AU (✓) MFBU (✓) FS Non-HH/Excluded Member Code _____

CA 2.1/ CA 371

Work Registration/Exemption Codes:
 GAIN _____ FS _____

TYPE OF AID REQUESTED (✓)
 Cash Aid Food Stamps None
 Full Medi-Cal Restricted Medi-Cal

MARITAL STATUS (✓)
 Married Never Married Separated
 Divorced Common Law Widowed

VERIFIED: Blind/Deaf/Disabled SAVE
 SSN Citizen/Immig.

COUNTY USE ONLY

FS NON-HH/EXCLUDED MEMBER (63-402)	FS WORK/TRAINING EXEMPTIONS (63-407.1, .2)	GAIN EXEMPTIONS (42-789 THRU 42-799)
1. Separate HH (Purchase/prepare) (.12, .13)	a. Under 16/60 or older	01 Age under 16
2. Separate HH (Elderly/disabled) (.15)	a.(1) 16/17 not H of H; or 16/17 in school/training at least 1/2 time	02 School Attendance
3. Roomer (must be listed in ⑬) (.211)	b. Mentally/physically unfit	03 Illness or Injury
4. Live-in attendant (.212)	c. GAIN registered	04 Age 60 or older
5. Other shared living quarters (.213)	d. Cares for child under 6 or incapacitated person	05 Incapacity
6. Ineligible alien (.221)	e. UIB registered	06 Remoteness
7. Boarder (must be listed in ⑬) (.3)	f. Participant in drug/alcohol program	07 Care of Another individual in HH
8. SSN disqualified (.227)	g. 30 hour week/min. x 30	08 Care of Child Under Age 3 (Full)
9. IPV disqualified (.223)	h. Meets student elig. reqs.	09 Pregnancy
10. Workfare sanctioned (.223)		10 Working 30 hours per week
11. SSI/SSP recipient (.224)		11 VISTA participant
12. Ineligible student (.226)		12 Care of Child Under Age 3 (Limited)
13. Work req. disqualified (.227)		
14. Questionable Citizenship (403.312)		

3 For each CHILD living in the home, child of the home for a short time, or child you claim, a tax dependent, give us all the facts. But if you are applying for Restricted Medi-Cal, DO NOT give us any facts in any of the shaded boxes, such as Citizenship/Immigration Status, Social Security Number, and/or Birthplace.

COUNTY USE ONLY

CA (A) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZENSHIP/IMMIGRATION STATUS (✓)		CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		SFU (✓)	AU (✓)	MFBUL (✓)	Declaration of Paternity Completed	FS Non-HH/Excluded Member Code			
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		Sponsored? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEATH		DISABILITY		ABSENCE		UNEMPLOYMENT	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO		CA 2.1/CA 371		N/A		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		MOTHER'S NAME										Work Registration/Exemption Codes: GAIN FS	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME								Verified: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> Deprivation <input type="checkbox"/> Age <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen/Immig. <input type="checkbox"/> SSN Date: _____	

CA (B) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZENSHIP/IMMIGRATION STATUS (✓)		CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		SFU (✓)	AU (✓)	MFBUL (✓)	Declaration of Paternity Completed	FS Non-HH/Excluded Member Code			
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		Sponsored? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEATH		DISABILITY		ABSENCE		UNEMPLOYMENT	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO		CA 2.1/CA 371		N/A		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		MOTHER'S NAME										Work Registration/Exemption Codes: GAIN FS	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME								Verified: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> Deprivation <input type="checkbox"/> Age <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen/Immig. <input type="checkbox"/> SSN Date: _____	

CA (C) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZENSHIP/IMMIGRATION STATUS (✓)		CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		SFU (✓)	AU (✓)	MFBUL (✓)	Declaration of Paternity Completed	FS Non-HH/Excluded Member Code			
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		Sponsored? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEATH		DISABILITY		ABSENCE		UNEMPLOYMENT	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO		CA 2.1/CA 371		N/A		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		MOTHER'S NAME										Work Registration/Exemption Codes: GAIN FS	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME								Verified: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> Deprivation <input type="checkbox"/> Age <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen/Immig. <input type="checkbox"/> SSN Date: _____	

CA (D) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZENSHIP/IMMIGRATION STATUS (✓)		CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		SFU (✓)	AU (✓)	MFBUL (✓)	Declaration of Paternity Completed	FS Non-HH/Excluded Member Code			
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		Sponsored? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEATH		DISABILITY		ABSENCE		UNEMPLOYMENT	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO		CA 2.1/CA 371		N/A		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		MOTHER'S NAME										Work Registration/Exemption Codes: GAIN FS	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME								Verified: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> Deprivation <input type="checkbox"/> Age <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen/Immig. <input type="checkbox"/> SSN Date: _____	

CA (E) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZENSHIP/IMMIGRATION STATUS (✓)		CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		SFU (✓)	AU (✓)	MFBUL (✓)	Declaration of Paternity Completed	FS Non-HH/Excluded Member Code			
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		Sponsored? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEATH		DISABILITY		ABSENCE		UNEMPLOYMENT	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO		CA 2.1/CA 371		N/A		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		MOTHER'S NAME										Work Registration/Exemption Codes: GAIN FS	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME								Verified: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> Deprivation <input type="checkbox"/> Age <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen/Immig. <input type="checkbox"/> SSN Date: _____	

4 If the other parent(s) of the child(ren) or unborn does not live with you, complete below:

PARENT NAME	REASON
PARENT NAME	REASON

CA FS MC	5 Has anyone changed citizenship/immigration status in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:		COUNTY USE ONLY
WHO	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)
<input type="checkbox"/> Verif. on File <input type="checkbox"/> CA 64 <input type="checkbox"/> MC 13			
CA FS	6 A. Is a foster child living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:		
FS	B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CA FS MC	7 Has anyone ever used any other name (maiden, adoptive, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:		
WHO	OTHER NAME(S) USED		
WHO	OTHER NAME(S) USED		
CA FS MC	8 A. Does everyone live in California? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain:	YES	NO
	B. Does everyone plan to stay in California permanently? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain:		
	C. Does anyone own, lease or maintain a home outside California? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:		
	D. Is anyone currently getting public assistance outside California? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:		
	E. Is anyone planning to leave California for more than 60 days? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:		
<input type="checkbox"/> Property <input type="checkbox"/> PA Calif. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No			
MC	9 Are you or any family member claimed as a deduction for income tax purposes by a person who does not live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:		
WHO CLAIMS FAMILY MEMBER	ADDRESS	RELATIONSHIP	
WHO CLAIMS FAMILY MEMBER	ADDRESS	RELATIONSHIP	
CA FS MC	10 A. Has anyone's Cash Aid, Food Stamps or Medi-Cal been stopped due to: non-cooperation during a quality control review, work or training sanctions, or for any other reason? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:		
WHO	WHY	WHEN	WHAT COUNTY/STATE
CA FS	B. Has anyone's Cash Aid or Food Stamps been stopped for 6 months, 12 months, or forever due to welfare fraud or an Intentional Program Violation? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:		
WHO	WHY	WHEN	WHAT COUNTY/STATE
FS	11 Does anyone living with you buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain who:	Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	
FS	12 Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain who:	Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	

CA FS MC 13 A. Does anyone pay you for meals and/or a room? YES NO
 If "YES", complete below:

WHO	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$		

COUNTY USE ONLY

Household Elects		ROOMER
BOARDER	HH MEMBER	

FS B. Do you pay someone else for meals and/or a room? YES NO
 If "YES", complete below:

NAME	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$		

FS 14 Does anyone get food from any of the following programs? YES NO

Meals on Wheels Communal dining facility for the elderly or disabled
 Food distribution program operated by a Native American reservation
 Other food program

WHO	NAME OF PROGRAM	WHO	NAME OF PROGRAM

FS Eligible Institution
 YES NO

CA Eligible
 YES NO

MC B. Does the person who is in a hospital or nursing home have a spouse or minor child at home? YES NO

CA FS MC 16 Is anyone age 16 or older enrolled in school, college, or a training program? YES NO
 If "YES", complete below:

A. NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING?
		ENROLLED CHECK (✓) <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):			<input type="checkbox"/> YES <input type="checkbox"/> NO
B. NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING?
		ENROLLED CHECK (✓) <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):			<input type="checkbox"/> YES <input type="checkbox"/> NO

School Enrollment Verif.
 YES NO

Date Verified:
 YES NO

School Enrollment Verif.
 YES NO

Date Verified:
 YES NO

FS Eligible Student

CA FS MC B. Complete below for anyone enrolled in college or attending a similar educational institution.

TERM	TUITION/FEES PER TERM	BOOKS, EQUIPMENT, ETC., PER TERM
<input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	\$	\$
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED
TRANSPORTATION COST PER WEEK	AMOUNT PAID BY CAR POOL MEMBERS	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY
\$	\$	\$

Expenses Verified
 YES NO

Date Verified:

Financial Aid
 YES NO

CA 17 Is anyone under age 19 and pregnant or a teen parent? YES NO
 If "YES", complete below:

NAME	AGE	CHECK (✓) STATUS
		<input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent
SCHOOL STATUS, CHECK (✓)		
<input type="checkbox"/> High School Diploma	<input type="checkbox"/> GED	<input type="checkbox"/> Not Attending School (explain):
<input type="checkbox"/> Currently Attending School	<input type="checkbox"/> Other (explain):	

Verified:
 Packet given to applicant (Cal-Learn Informing)
 Referred to GAIN

Verified:
 Packet given to applicant (Cal-Learn Informing)
 Referred to GAIN

CA FS MC 18 Has anyone been in the U.S. Military Service or the spouse, parent or child of a person who has been in the military service? YES NO
 If "YES", explain: (List name, branch of service, etc.)

CA 5

CA FS MC	19	Is anyone including children working now or expect to be working in the next 2 months? If "YES", complete below: (NOTE: If self-employed, list and explain expenses on a separate sheet of paper and attach it to this form.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY Earnings and Expenses (✓)Check if exempt
NAME		SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER NAME	OCCUPATION
DAYS/HOURS WORKED PER MONTH		PAY DATE(S)	WAGES BEFORE DEDUCTIONS \$ _____ per	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO
NAME		SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER NAME	OCCUPATION
DAYS/HOURS WORKED PER MONTH		PAY DATE(S)	WAGES BEFORE DEDUCTIONS \$ _____ per	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO
CA FS MC 20 A. Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job? If "YES", complete below and (✓) work or training		<input type="checkbox"/> YES <input type="checkbox"/> NO		Child Care Informing <input type="checkbox"/> CAAP <input type="checkbox"/> SCC <input type="checkbox"/> NET <input type="checkbox"/> Verified Is there another person in MFBU who could provide care? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, who: _____
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	AMOUNT/WHEN \$ _____ EVERY
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	AMOUNT/WHEN \$ _____ EVERY
CA FS MC B. Does anyone get his/her child care costs paid for them? Include costs paid by relative or friend, Department of Education, Block Grant, CARE, TCC, NET, GAIN, etc. If "YES", complete below:		<input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME OF CHILD	AMOUNT \$	HOW OFTEN	WHO PAYS	
NAME OF CHILD	AMOUNT \$	HOW OFTEN	WHO PAYS	
CA FS MC 21 Does anyone pay child or spousal support? If "YES", complete below:		<input type="checkbox"/> YES <input type="checkbox"/> NO		Court Order on File? <input type="checkbox"/> YES <input type="checkbox"/> NO Amount Ordered \$ _____
WHO PAYS	FOR WHOM?	AMOUNT PER MONTH \$ _____		
CA FS MC 22 Has anyone stopped or refused work or training within the last 60 days? If "YES", complete below:		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> CA <input type="checkbox"/> FS <input type="checkbox"/> MC 30 days 60 days 30 days Empl. Statement <input type="checkbox"/> YES <input type="checkbox"/> NO Good Cause Determ. <input type="checkbox"/> YES <input type="checkbox"/> NO Voluntary Quit? <input type="checkbox"/> YES <input type="checkbox"/> NO FS Vol. Quit or Refusal <input type="checkbox"/> Work history last 90 days.
NAME	NUMBER OF HOURS OF WORK/TRAINING Last month _____ This month _____	Did this person get or expect to get wages or benefits this month? If "YES", complete below. <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM		LAST PAYCHECK RECEIVED (DATE):	AMOUNT BEFORE DEDUCTIONS: \$ _____	
		EXPECTED CHECK (DATE):	AMOUNT BEFORE DEDUCTIONS: \$ _____	
		LAST DAY OF WORK/TRAINING:	TIPS OR COMMISSIONS <input type="checkbox"/> YES AMOUNT \$ _____ <input type="checkbox"/> NO	
		REASON FOR LEAVING JOB/TRAINING:		
NAME	NUMBER OF HOURS OF WORK/TRAINING Last month _____ This month _____	Did this person get or expect to get wages or benefits this month? If "YES", complete below. <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM		LAST PAYCHECK RECEIVED (DATE):	AMOUNT BEFORE DEDUCTIONS: \$ _____	
		EXPECTED CHECK (DATE):	AMOUNT BEFORE DEDUCTIONS: \$ _____	
		LAST DAY OF WORK/TRAINING:	TIPS OR COMMISSIONS <input type="checkbox"/> YES AMOUNT \$ _____ <input type="checkbox"/> NO	
		REASON FOR LEAVING JOB/TRAINING:		
CA FS MC 23 Is anyone on strike? If "YES", complete below:		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> CA <input type="checkbox"/> FS <input type="checkbox"/> MC 30 days 60 days 30 days Empl. Statement <input type="checkbox"/> YES <input type="checkbox"/> NO Good Cause Determ. <input type="checkbox"/> YES <input type="checkbox"/> NO Voluntary Quit? <input type="checkbox"/> YES <input type="checkbox"/> NO FS Vol. Quit or Refusal <input type="checkbox"/> Work history last 90 days.
NAME OF STRIKER	NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM			
NAME OF UNION				
DATE WENT ON STRIKE	GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE			
CA FS MC 24 Has anyone applied for or received unemployment or disability insurance benefits in the last 12 months? If "YES", complete below:		<input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	

FS (25) Who do you want as the head of your food stamp household?

CA (26) Has any parent living in the home worked or been in training in the past 5 years. If "YES", complete below: YES NO
FS Include all work done outside the U.S.
MC Include work done in exchange for something besides money, such as rent, food, utilities or anything else.

A. NAME IS HE/SHE A NATIVE AMERICAN? YES NO
IF "YES", LIST TRIBE:

COUNTY USE ONLY
H of H picked by: HH CO
Principal earner/UIB requirements
Earnings from month prior to month of application
App Date:
Earnings from to

Table with 6 columns: Name and Address of Employer or Training Program, When Employed From To, Amount Paid, Name and Address of Employer or Training Program, When Employed From To, Amount Paid. Includes checkboxes for Work or Training.

Table with 2 columns: MO/YR, Amount Paid. Includes checkboxes (26) A and (26) B.

B. NAME IS HE/SHE A NATIVE AMERICAN? YES NO
IF "YES", LIST TRIBE:

Table with 6 columns: Name and Address of Employer or Training Program, When Employed From To, Amount Paid, Name and Address of Employer or Training Program, When Employed From To, Amount Paid. Includes checkboxes for Work or Training.

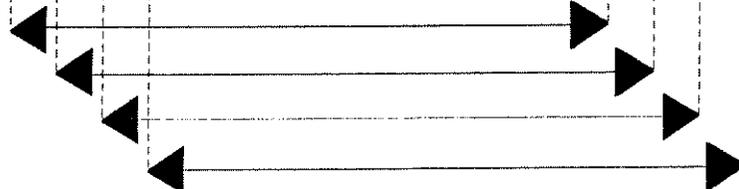
COUNTY USE ONLY

PRINCIPAL EARNER (PE) DATE OF APPLICATION QUARTER OF APPLICATION

PE* eligible or would have been eligible to receive UIB in last 12 months? YES NO
Redetermination - Federal eligibility was determined per CA 2 JA 2 SAWS 2 MC 210 Date:

Table with 4 rows: Year, Quarter, Work (\$50), Training (GAIN, etc.). Includes a 'Do only for the PE*' column.

Are there 6 quarters of work and/or training within any one of the 13 consecutive quarter periods? YES NO



The last day PE worked? Case is Non-Fed Fed effective
*Principal Earner - the parent who earned the most income in the last 24 months prior to the month of application.

TOTAL \$ \$
(26) A Tribal JOBS Referral YES NO
UIB: Must apply for Currently Receiving Ineligible/Reason: Verif. on file
(26) B Tribal JOBS Referral YES NO
UIB: Must apply for Currently Receiving Ineligible/Reason: Verif. on file

CA FS MC (27) A. Does anyone, including children, get or expect to get money from any source listed below?
 Check (✓) YES or NO for each item.

COUNTY USE ONLY

	YES	NO		YES	NO
• Training -Work Study, JTPA, GAIN, or other program	<input type="checkbox"/>	<input type="checkbox"/>	• Strike benefits	<input type="checkbox"/>	<input type="checkbox"/>
-Other training allowance	<input type="checkbox"/>	<input type="checkbox"/>	• Veterans Administration		
• Educational grants, loans and scholarships	<input type="checkbox"/>	<input type="checkbox"/>	-Aid and attendance	<input type="checkbox"/>	<input type="checkbox"/>
• Welfare			-Disability	<input type="checkbox"/>	<input type="checkbox"/>
-AFDC	<input type="checkbox"/>	<input type="checkbox"/>	-GI Bill/VEAP	<input type="checkbox"/>	<input type="checkbox"/>
-Refugee Assistance	<input type="checkbox"/>	<input type="checkbox"/>	• Military allotment or pension	<input type="checkbox"/>	<input type="checkbox"/>
-GA/GR (General Assistance/Relief)	<input type="checkbox"/>	<input type="checkbox"/>	• Railroad Retirement		
• State Benefits			-Disability	<input type="checkbox"/>	<input type="checkbox"/>
-UIB (Unemployment Insurance)	<input type="checkbox"/>	<input type="checkbox"/>	-Retirement	<input type="checkbox"/>	<input type="checkbox"/>
-DIB/SDI (State Disability)	<input type="checkbox"/>	<input type="checkbox"/>	• Other federal, state, or local government agency		
• Workers Compensation	<input type="checkbox"/>	<input type="checkbox"/>	-Disability	<input type="checkbox"/>	<input type="checkbox"/>
• Support			-Retirement	<input type="checkbox"/>	<input type="checkbox"/>
-Child/spousal	<input type="checkbox"/>	<input type="checkbox"/>	• Other pension or disability	<input type="checkbox"/>	<input type="checkbox"/>
-(Money for) Medical bills or premiums	<input type="checkbox"/>	<input type="checkbox"/>	• Loans, gifts, contributions	<input type="checkbox"/>	<input type="checkbox"/>
• Social Security Benefits			• Income from rental property	<input type="checkbox"/>	<input type="checkbox"/>
-Disability	<input type="checkbox"/>	<input type="checkbox"/>	• Winnings (bingo, lottery, prizes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
-Retirement or survivors	<input type="checkbox"/>	<input type="checkbox"/>	• Sale of notes, contracts, trust deeds, promissory notes	<input type="checkbox"/>	<input type="checkbox"/>
-SSI	<input type="checkbox"/>	<input type="checkbox"/>	• Other (Explain)	<input type="checkbox"/>	<input type="checkbox"/>
• Legal or insurance settlements/ court actions pending	<input type="checkbox"/>	<input type="checkbox"/>			

- Casualty Unit Notified
 Verif(s) on File
 Explain Anticip. Income

If "YES", complete below:

(✓) if exempt

WHO	WHAT	AMOUNT (BEFORE DEDUCTIONS, IF ANY)	WHEN	HOW OFTEN	CA	FS	MC
		\$					
		\$					
		\$					

CA FS MC B. Does anyone expect a change in the current amount of money received now, such as a cost-of-living raise? YES NO
 If "YES", complete below:

WHO	WHAT	AMOUNT	WHEN
		\$	

CA FS MC (28) Does anyone get housing or rent, utilities, food or clothing free or in exchange for work? YES NO
 If "YES", complete below:

ITEM RECEIVED	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM
Housing or rent <input type="checkbox"/> Free <input type="checkbox"/> Exchange		\$	
Utilities <input type="checkbox"/> Free <input type="checkbox"/> Exchange		\$	
Food <input type="checkbox"/> Free <input type="checkbox"/> Exchange		\$	
Clothing <input type="checkbox"/> Free <input type="checkbox"/> Exchange		\$	

In-Kind income
 Verif. on file YES NO

Partial	Full	
	Earned	Unearned
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CA FS MC (29) A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.? YES NO
 If "YES", complete below. Include land and/or buildings in which the title is shared.

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	OWNER(S)	AMOUNT OWED
				\$

Home Exempt YES NO
 Other Real Property YES NO

Market Value \$ _____
 Amount Owed \$ _____
 Net Value \$ _____
 Lien Applicable YES NO

CA FS MC B. Does anyone own a house that is not lived in now that he/she hopes to return to someday? YES NO
 If "YES", complete below:

OWNER OF PROPERTY	PROPERTY ADDRESS	EXPECTED DATE OF RETURN (IF KNOWN)

Total Countable property: Page 7
 (List totals on page 9)

AFDC \$ _____
 FS \$ _____
 MC \$ _____

CA **FS** **MC** **(30) A. Does anyone have any of the following resources?**
 Check (✓) each item either "YES" or "NO".

- Include all resources owned, used, controlled, shared or held jointly with or for another person(s).
- Include resources on which persons listed in (2) and (3) are named (even for convenience only).
- The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Trust funds (whether or not available)		
Uncashed checks (on hand or elsewhere)			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Savings accounts - children's and adult's			IRA or Keogh plans, etc.		
Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)		
Credit union accounts			Employee deferred compensation plans		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance or annuity		
Oil, mining, or mineral rights			Life estate interest in any property		
Burial/Funeral arrangements, burial trusts, plots or burial space			Other (explain)		
Income tax refund					

COUNTY USE ONLY

Trust Fund/Not Court Ordered

Court Petitioned Date _____

Resource Verified: Explain how: _____

Total Value = _____

Burial Reserve or Trust

Revocable

Irrevocable

Designated Fund and Current Value \$ _____

Restricted Account

IF "YES", COMPLETE BELOW:

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
				\$
				\$
				\$
				\$

Check (✓) if exempt

AFDC	FS	MC

CA **FS** **MC** **B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?** YES NO

If "YES", complete below:

WHO	SOURCE OF MONEY	AMOUNT	HOW OFTEN
		\$	
		\$	

MC **(31) Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services?** YES NO

If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
\$			
\$			
\$			

Verified YES NO

Lien Applicable YES NO

Security Agreement YES NO

MC 174 completed and sent YES NO

CA **FS** **MC** **(32) Does anyone own any personal property which costs at least \$100 or which is now worth at least \$100, such as:** YES NO

- boats, 3-wheelers, off-road vehicles, snowmobiles, mobile homes, campers, or trailers.
- guns; tools; business or sporting equipment, etc.
- pets or livestock.
- jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

Do not include wedding and engagement rings or heirlooms.

If "YES", complete below:

ITEM	DATE BOUGHT	PURCHASE PRICE: (If a gift check (✓) and list current value)	AMOUNT OWED	ITEM	DATE BOUGHT	PURCHASE PRICE: (If a gift check (✓) and list current value)	AMOUNT OWED
		<input type="checkbox"/> Gift				<input type="checkbox"/> Gift	
		\$	\$			\$	\$
		<input type="checkbox"/> Gift				<input type="checkbox"/> Gift	
		\$	\$			\$	\$
		<input type="checkbox"/> Gift				<input type="checkbox"/> Gift	
		\$	\$			\$	\$

Pickle Program: \$500 + limit.

Total Countable property: Page 8
(List totals on page 9)

AFDC \$ _____

FS \$ _____

MC \$ _____

CA FS MC **33** A. Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else? YES NO
 (List any property sold or traded within the last 2 years for Cash Aid, within the last 3 months for Food Stamps and within the last 3 years (36 months) for Medi-Cal).
 If "YES", explain what and when:

COUNTY USE ONLY
 Closed Bank Accts:
 Food Stamps in last 3 months
 Cash Aid in last 2 years
 Medi-Cal in last 3 years (36 months)
 Adequate Consideration
 Spenddown
 LTC ONLY
 Total Nonexempt Property
 \$ _____

MC B. Has anyone received money from insurance or court settlements, inheritance, lottery or back pay in the last 3 years (36 months)? YES NO
 If "YES", complete below:

SOURCE	DATE RECEIVED	AMOUNT
		\$ _____
		\$ _____

CA FS MC **34** Does anyone own, have the use of or have their name on the registration of any motor vehicle, even if not running? YES NO
 If "YES", complete below. Look at your registration to get facts for each vehicle:

	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)
OWNER OF VEHICLE			
NAME OF PERSON WHO USES VEHICLE			
YEAR/MAKE/MODEL			
LICENSE NUMBER			
ESTIMATED VALUE	\$ _____	\$ _____	\$ _____
BALANCE OWED	\$ _____	\$ _____	\$ _____
LICENSED? (✓ BOX)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOW DO YOU USE THE VEHICLE	<input type="checkbox"/> As a Home <input type="checkbox"/> General Use <input type="checkbox"/> Transportation to work <input type="checkbox"/> Other:	<input type="checkbox"/> As a Home <input type="checkbox"/> General Use <input type="checkbox"/> Transportation to work <input type="checkbox"/> Other:	<input type="checkbox"/> As a Home <input type="checkbox"/> General Use <input type="checkbox"/> Transportation to work <input type="checkbox"/> Other:

Compute Vehicle Valuation in Section Below
 Verifications viewed

 Vehicle value
 (Enter Date of blue book issue or other documentation)
 (1) Date: _____ \$ _____
 (2) Date: _____ \$ _____
 (3) Date: _____ \$ _____

COUNTY USE ONLY - VEHICLES

FOOD STAMPS	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)
(A) Is vehicle a home, income producing or used for a disabled household member? (63-501.521)	<input type="checkbox"/> YES (Exclude) <input type="checkbox"/> NO Go to B	<input type="checkbox"/> YES (Exclude) <input type="checkbox"/> NO Go to B	<input type="checkbox"/> YES (Exclude) <input type="checkbox"/> NO Go to B
(B) 1. Is vehicle for home use? (Allow one vehicle only) OR 2. Is vehicle used for job search, employment or training? (63-501.523)	<input type="checkbox"/> YES Go to C Use Excess Value <input type="checkbox"/> NO Go to C and D Use Greater Value	<input type="checkbox"/> YES Go to C Use Excess Value <input type="checkbox"/> NO Go to C and D Use Greater Value	<input type="checkbox"/> YES Go to C Use Excess Value <input type="checkbox"/> NO Go to C and D Use Greater Value

(C) Fair Market Values-FS

FMV	Minus \$4,500	Minus \$4,500	Minus \$4,500	Minus \$4,500
Excess Value				

(D) Equity Values-FS

FMV	Minus Encumbrance	Equity Value
Equity Value		

Class	AFDC			Medi-Cal	
	(1)	(2)	(3)	(1)	(2)
Year				DMV/YR/ Class Code	_____
Value				Vehicle Market Value	\$ _____ \$ _____
Amount Owed				Less Encumbrances	\$ _____ \$ _____
Net Value				Net Value	\$ _____ \$ _____
\$1500 Exempt: \$4500 Exempt: 1 MV Only				Exempt	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
Total Value					
Excess Value					

TOTALS: VEHICLE FS

Excess Value \$ _____
 Equity Value \$ _____

Grand Total Countable property
 (List totals from pages 7, 8, and 9)

Page	AFDC	FS	MC
(9)	\$ _____	\$ _____	\$ _____
(8)	\$ _____	\$ _____	\$ _____
(7)	\$ _____	\$ _____	\$ _____
Total	\$ _____	\$ _____	\$ _____

CA FS MC **35** A. Does anyone have any housing costs? YES NO
 If "YES", complete below:

COUNTY USE ONLY

Housing verified YES NO

	HOW MUCH	HOW OFTEN BILLED
Rent	\$	
House (mortgage) payment	\$	
Property taxes (if not in house payment)	\$	
Insurance (if not in house payment)	\$	
Other (explain)	\$	

Total housing \$ _____

Shared housing
 YES NO

CA FS MC **B.** Does anyone else pay all or part of these housing costs? Include any rental assistance programs, such as HUD, Section 8, etc. YES NO
 If "YES", complete below:

TYPE OF HOUSING	WHO PAYS	HOW MUCH	HOW OFTEN BILLED
		\$	
		\$	

FS **36** A. Does anyone have any utility costs? YES NO
 If "YES", complete below:

	YES	NO	HOW MUCH	HOW OFTEN BILLED
Gas or other fuel			\$	
Electricity or other fuel			\$	
Is the gas or electricity or other fuel used to heat or cool your house or cook your food?			\$	
Water			\$	
Sewage			\$	
Garbage or trash			\$	
Telephone (Basic rate for one phone plus tax)			\$	
Installation of utilities			\$	
Other (explain)			\$	

Utilities verified:
 YES NO

Metered
 YES NO

Client elects:
 Actual
 If Actual, Total Utilities
 \$ _____

SUA
 SUA prorated:
 YES NO
 If YES, show computation:

FS **B.** Does anyone pay all or part of these utility costs? Include Low Income Energy Assistance, etc. YES NO
 If "YES", complete below:

TYPE OF UTILITY	WHO	HOW MUCH (\$ OR %)	HOW OFTEN BILLED

Document:

FS **37** You can authorize someone outside your household to pick up your Food Stamps for you or to use them to buy food. If you would like to authorize someone, complete below:

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		()

Authorized Representative's I.D. Verified

CA MC 38 Did anyone make a payment for health care services or get medical/pregnancy treatment this month or in the last three months before this month? YES NO
 If "YES", complete below:

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDICAL FOR THOSE MONTHS	
		YES	NO	YES	NO

COUNTY USE ONLY
 Retroactive Application
 Retro Only
 Retro and Cont.
 MC 210A

CA MC 39 Does anyone have MEDICARE coverage? YES NO
 If "YES", complete below:

PERSON COVERED	MEDICARE CLAIM NUMBER	(✓)	MONTHLY PREMIUM	
			DEDUCTED FROM CHECK	PAID BY YOU
			Part A <input type="checkbox"/>	Part B <input type="checkbox"/>
			Part A <input type="checkbox"/>	Part B <input type="checkbox"/>

MEDICARE referral

CA MC 40 Does anyone have health, dental, vision, hospitalization or long term care insurance or health plans such as Kaiser, Blue Cross, CHAMPUS, etc.? YES NO
 If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			\$	
			\$	

Health Care Options
 Explanation given Referral NA
 DHS 6155

CA MC 41 Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? YES NO
 If "YES", complete below:

INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID
		\$	
		\$	

DHS 6155

CA MC 42 Is anyone's health insurance expected to end or has it ended within the last 60 days? YES NO
 If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			\$	
			\$	

DHS 6155

CA MC 43 Does anyone have a physical or emotional problem which makes it difficult for them to work or take care of their needs? YES NO
 If "YES", complete below and (✓) if caused by injury or accident:

NAME OF PERSON	TYPE OF PROBLEM	INJURY/ ACCIDENT	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY
		<input type="checkbox"/>		
		<input type="checkbox"/>		

DED Packet
 3rd Party Liability

CA 44 A. Does anyone have a medical condition(s) or situation(s) that requires any of the following? YES NO
 Check (✓) each item YES or NO:

	YES	NO	YES	NO
Special diet—prescribed by a doctor				
Special transportation need				
Special telephone or other equipment				
Housework (no one in the home can do it)				

Verified YES NO
 Special Need YES NO
 Amount \$

MC B. Is anyone a disabled person who is working and who has medical expenses, such as a wheelchair, etc., which are needed for the person to be able to work? YES NO
 If "YES", complete below:

NAME OF PERSON	TYPE OF EXPENSE	AMOUNT
		\$
		\$

IRWE (QMB and SGA)

CA 45 Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden unusual circumstances such as an earthquake, fire or flood?
If "YES", explain below. YES NO

COUNTY USE ONLY

Special Need Verified:
 YES NO
Eligible for Special Need
 YES NO

CA MC 46 The following services are available. Your answers to these questions will not affect your eligibility.

YES NO

- A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.
 - Do you want more information about CHDP Services?
 - Do you want CHDP medical or dental services?.....
 - Do you need help making appointments or with transportation to CHDP services?
- B. If you are pregnant, you can get help finding a doctor, getting transportation to see the doctor, and other help. Do you want to talk to someone about this help?
- C. Are you breastfeeding a child?
If YES, have you given birth within the last three months?

If you checked "YES" to either of these questions, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).

- D. Do you want information about Family Planning Services?.....

- CHDP Brochure and Explanation Given Date: _____
- Referral
- Pregnant Parent or Guardian of child under 5
- Breastfeeding Postpartum
- WIC referral
- Family Planning Information Given
- Referred Date: _____

CERTIFICATION

I understand the questions on this form. I understand the penalties, including the disqualification and/or welfare fraud penalties, if I give wrong facts or fail to report all facts or situations on purpose that affect my eligibility or benefits for Cash Aid, Food Stamps and Medi-Cal. I understand the specific penalties for Cash Aid or Food Stamps include fines, jail/prison, and/or stopping my benefits for a period of time or forever.

I also understand that

- any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and employment agencies, etc.
- all facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my Cash Aid, Food Stamps, and Medi-Cal may be denied or stopped.
- my case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- the county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for Cash Aid, Food Stamps, and Full Medi-Cal.
- the Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of an immigrant household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- I must apply for and keep any available health coverage if no cost is involved; if I don't, my Medi-Cal will be denied or stopped.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY						
	REGULATIONS MET?					
	CA		FS		MC	
	YES	NO	YES	NO	YES	NO
Residency						
Deprivation						
Age						
Citizenship/Alien status						
School enrollment						
Pregnancy verified/WIC Referral						
SSN						
Income—Gross and net income						
Property—Within limits and verified amount \$						
Work registration						
Sponsored alien						
Federal participation established (If "NO", explain)						
HCO Presentation Referred						

FOOD STAMP TESTS	
Categorically Eligible	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
Gross Income Test Household Size Gross Monthly Income \$	
Gross Income Eligible	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
Separate HH Income Test Household Size Gross Monthly Income \$	
Eligible for Separate HH Status	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aged/Disabled	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
DFA 285-C If NO, why:	<input type="checkbox"/> YES <input type="checkbox"/> NO

AFDC/MC SFU Size	AUM/FBU Size
<input type="checkbox"/> INELIGIBLE (REASON)	
<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> SELECTS CAAP
<input type="checkbox"/> REDETERMINATION	AUTHORIZATION DATE
ELIGIBILITY CONDITIONS MET (DATE):	EFFECTIVE DATE
ELIGIBILITY WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)	DATE

FS:	HH Size:
<input type="checkbox"/> INELIGIBLE (REASON)	
<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> RECERTIFICATION
<input type="checkbox"/> RECERTIFICATION	AUTHORIZATION DATE
ELIGIBILITY WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)	DATE